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USAID/GLOBAL HEALTH EVALUATION AND LEARNING SUPPORT ACTIVITY (GH EvaLS)

USAID ORGANIZED NETWORK OF SERVICES FOR EVERYONE'S HEALTH (ONSE) IN MALAWI ENDLINE PERFORMANCE EVALUATION

APRIL 2023

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Cover Photo: Hector Malaidza: A focus group discussion session with Men Champions in Karonga District

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ABSTRACT

PROGRAM PURPOSE/DESCRIPTION

GH EvaLS conducted an endline performance evaluation of the USAID-funded Organized Network of Services for Everyone's Health (ONSE) Activity in Malawi, which was implemented from November 15, 2016, to June 30, 2022. ONSE's purpose was to support efforts by the Government of Malawi (GOM) to reduce maternal, newborn, and child mortality in 16 districts and bring essential health care services to more than half of Malawi's population. This evaluation sought to assess the extent to which the Activity achieved its objectives, provide insights into factors that facilitated and limited increased service utilization, and document progress made toward building the capacity of the GOM to deliver quality health services.

KEY QUESTIONS

1. To what extent did the Activity's interventions achieve their intended results?
2. To what extent did ONSE improve access to priority high-impact Essential Health Package interventions in the target health facilities and community service delivery points?
3. What are the most significant accomplishments, best practices, and lessons learned from the ONSE Activity?
4. What were the contextual factors such as socioeconomic factors, gender, demographic factors, environmental characteristics, baseline health conditions, health services characteristics, and so forth that affected implementation and outcomes of the ONSE Activity?

METHODOLOGY

The evaluation used a mixed-methods approach. The evaluation team conducted a desk review of materials that provided secondary quantitative data for analysis, along with a limited amount of analysis from two primary data sets. Qualitative data came from interviews with key informants, focus group discussions, and group interviews for a total of 89 individuals participating. Qualitative data is subjective and susceptible to a number of biases; the team sought to mitigate and minimize this bias through the use of multiple data sources, a robust and systematic analysis of information collected, and triangulation of results.

KEY FINDINGS, CHALLENGES AND MITIGATION STRATEGIES

In general, ONSE achieved its intended results, including improving access to high-priority services, with most of targets met or exceeded. However, it fell short in several other areas (e.g., nutrition interventions, couple-years of protection, etc.). Regardless, participants appreciated ONSE's efforts, especially interventions that were aimed at health systems strengthening and specific, measurable, achievable, realistic, and timed (SMART) capacity building. These were noted as ONSE's main accomplishments and best practices. A number of challenges arose during ONSE's implementation, some of which were within its manageable interests (e.g., gaps in early collaborative efforts) and some of which were unforeseen and outside its ability to manage (e.g., the COVID-19 pandemic). ONSE mitigates many of these issues possible, but it remains to be seen whether the implemented interventions will be sustained.

KEY RECOMMENDATIONS

Because this was an endline evaluation, recommendations are structured around potential future activities. They include ensuring the use of a health systems strengthening approach, a focus on capacity

building, and that potential participating facilities are adequately assessed prior to implementation. Further, efforts should focus on better communication with partners, ensuring that sustainability and accountability are addressed in design, and that communities are well-engaged at all stages.

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The evaluation team of the USAID-funded Organized Network of Services for Everyone's (ONSE) Health Activity in Malawi acknowledges the support received for this assignment from the following:

- Representatives from Malawi's Ministry of Health who showed support for the Activity and provided useful insights from the government's perspective;
- USAID/Malawi team members who provided insights and guidance from the donor's perspective; and
- The ONSE team and implementing partners in the field who gave valuable time to answer questions and provided support through program documents.

The team is also grateful to the GH EvaLS team for their assistance and direct support during the preparation and field implementation of this evaluation and preparation of this report.

The team thanks all the staff of the local health facilities that were visited, as well as the local resource persons and groups contacted. They graciously gave their time to respond to interview questions, share experiences and concerns, and make suggestions for future improvements.

Finally, the team expresses its deepest appreciation to all those who generously reviewed the findings, conclusions, and recommendations of this report and provided feedback.

ACRONYMS AND ABBREVIATIONS

Acronym/ Abbreviation	Definition
AMEP	Activity Monitoring and Evaluation Plan
ANC	Antenatal Care
CHAG	Community Health Action Group
COVID-19	Coronavirus Disease 2019
DHIS2	District Health Information System 2
DHO	District Health Office (now the Director of Health and Social Services)
EHP	Essential Health Package
FGD	Focus Group Discussion
FHP	Family Health Package
FP	Family Planning
GH EvaLS	Global Health Evaluation and Learning Support Activity
GI	Group Interview
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (German Development Agency)
GOM	Government of Malawi
HIS	Health Information Systems
HMIS	Health Management Information System
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
IP	Implementing Partner
IR	Intermediate Result
ISS	Integrated Supportive Supervision
KII	Key Informant Interview
LMIS	Logistics Management Information System
LOA	Life of Award/Activity
MCHN	Maternal and Child Health and Nutrition
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Non-governmental organization
ONSE	Organized Network of Services for Everyone's Health
PENTA III	Pentavalent Vaccine Third Dose
PY	Project Year
RH	Reproductive Health
RMNCH	Reproductive, maternal, newborn, and child health
SMART	Specific, Measurable, Achievable, Realistic, and Timed
USAID	United States Agency for International Development
USG	United States Government
WASH	Water, Sanitation, and Hygiene
YFHS	Youth-Friendly Health Services

EXECUTIVE SUMMARY

INTRODUCTION

The Global Health Evaluation and Learning Support (GH EvaLS) Activity conducted an endline performance evaluation of the United States Agency for International Development (USAID)-funded Organized Network of Services for Everyone's (ONSE) Health Activity in Malawi (also referred to as "the Activity"), implemented from November 15, 2016, to June 30, 2022. ONSE's overall purpose was to support Government of Malawi (GOM) efforts to reduce maternal, newborn, and child mortality in 16 districts and bring essential health care services to more than half of Malawi's population. The aim of the evaluation was to assess the extent to which Activity objectives were achieved regarding the quality of and access to care, provide in-depth insights into the factors that facilitated and limited increased service utilization at each level of service delivery, and document progress toward building the capacity of the GOM to deliver quality health services.

In addition, the evaluation helped identify promising best practices and lessons learned. The evaluation findings will inform the Malawi Ministry of Health (MOH), USAID, and other development partners in the design and prioritization of future investments to strengthen Malawi's health system. It will also feed into adaptations of current activities, as appropriate.

The target audiences for the ONSE Activity performance evaluation include:

1. The USAID Malawi Mission team;
2. GOM MOH units involved in prevention and care services at all levels;
3. Donors, collaborators, and partners;
4. Health care providers, managers, and beneficiaries (including clients, community members, and other stakeholders) at the country level; and
5. ONSE's Activity staff and implementing partners (IPs): prime implementer Management Systems for Health (MSH) and sub-award implementers.

ACTIVITY BACKGROUND

Although maternal and child health has improved in Malawi, the country faces several challenges. According to the Demographic and Health Survey[1] report (2015–2016), knowledge of family planning (FP) is almost universal in Malawi, with 98 percent of women and nearly 100 percent of men ages 15–49 knowing at least one method of contraception. Modern contraceptive use by currently married women has increased steadily during the last 25 years, from 7 percent in 1992 to 58 percent in 2015–2016. The total fertility rate declined markedly, from 6.7 children in 1992 to 4.4 in 2015–2016. The proportion of women aged 15–49 in Malawi who received antenatal care (ANC) from a skilled provider rose from 90 percent in 1992 to 95 percent in 2015–2016. Since 1990, the maternal mortality ratio (MMR) decreased from 1,100 maternal deaths per 100,000 live births to 439 per 100,000 in 2015–2016.

The percentage of children aged 12–23 months who received all basic vaccinations declined from 82 percent in 1992 to 64 percent in 2004 before rebounding to 81 percent in 2010 and then dropping again to 76 percent for 2015–2016. Of children under age 5, 37 percent are stunted (short for their age), 3 percent are wasted (thin for their height), 12 percent are underweight (thin for their age), and 5 percent are overweight (heavy for their height). The number of children dying before reaching their fifth birthday

[1] For a full list of documents reviewed, see Annex 3, List of Documents Reviewed.

declined from 234 deaths per 1,000 live births in 1992 to 63 deaths per 1,000 in 2015–2016. The infant mortality rate dropped to 31 deaths per 1,000 live births in 2021,[2] down from 234 deaths per 1,000 live births in 1992.

ONSE supported the GOM to provide essential health care services across 16 districts[3] in several priority health areas—maternal and child health and nutrition (MCHN); malaria; FP and reproductive health (RH); nutrition; and water, sanitation, and hygiene (WASH). The population covered by these interventions was between 11 million and 12 million.[4] ONSE's overall purpose was to support GOM efforts to reduce maternal, newborn, and child mortality through four main objectives:

1. Increasing access to priority health services;
2. Improving the quality of priority health services;
3. Strengthening the performance of health systems; and
4. Increasing demand for priority health services.

ONSE was implemented by MSH and its partners Banja La Mtsogolo, Development Innovations Group, Dimagi, Overseas Strategic Consulting, Ltd., and VillageReach.

ASSIGNMENT PURPOSE AND KEY QUESTIONS

The overall purpose of this endline performance evaluation is to assess the extent to which Activity objectives have been achieved regarding quality of and access to care; provide in-depth insights into the factors facilitating and limiting increased service utilization at each level of service delivery, and document progress made toward building the GOM's capacity to deliver quality health services.

USAID posed four primary questions (with several sub-questions) that guided this evaluation's inquiry and that were presented as specific objectives of the assignment:

1. **To what extent did the Activity's interventions achieve their intended results?**

   1a. What changes, if any, were made to activities, and how did those changes positively or negatively affect the project's achievement of its results (e.g., gaps and opportunities in retention and training of health workers)?

2. **To what extent did ONSE improve access to priority high-impact Essential Health Package (EHP) interventions in the target health facilities and community service delivery points?**

   2a. Of the capacity strengthening approaches employed by ONSE, which have most enabled the MOH to address systems-level issues at central and district levels?

3. **What are the most significant accomplishments, best practices, and lessons learned from the ONSE Activity?**

   3a. How were these best practices systematically scaled up?
   3b. What strategies, approaches, or methodologies did the Activity use to ensure sustainability?

[2] https://data.unicef.org/country/mwi/
[3] The 16 districts were Balaka, Chikwawa, Chitipa, Dowa, Karonga, Kasungu, Lilongwe, Machinga, Mangochi, Mchinji, Mulanje, Nkhata Bay, Nkhotakota, Ntcheu, Salima, and Zomba.
[4] The 2018 Malawi Census Preliminary Report estimated the total population for the 16 districts at 11,687,285.

3c. How were scale-up activities monitored and measured, and what level of sustainability was achieved?
3d. What were the challenges faced and how were they addressed/overcome?

4. **What were the contextual factors, such as socioeconomic factors, gender, demographic factors, environmental characteristics, baseline health conditions, health services characteristics, and so forth that affected implementation and outcomes of the ONSE Activity?**

4a. What key findings emerged?
4b. What were the challenges faced and how were they overcome?
4c. What more can be done in future activities of similar nature?

METHODS AND LIMITATIONS

This endline performance evaluation used a mixed-method design (mostly qualitative, as well as quantitative) to produce evidence and insights to answer the evaluation questions. Qualitative data comprised the majority of the analysis, drawing on reviews of documents (including Activity reports), planning meetings, key informant interviews (KIIs), focus group discussions (FGDs), and Mission debrief meetings.

At the national level, the evaluation team collected data in person from representatives of USAID/Malawi; the GOM MOH; ONSE and its IPs, and other agency representatives working in maternal and neonatal health, the Family Health Package (FHP), supply chain management, and other relevant areas. At the district level, officers and representatives from the public sector provided insights into health system strengthening (HSS) efforts, including supply chain systems and capacity building strategies. Likewise, health service providers from the public and private sectors participated in interviews regarding training and other support received through the Activity; they also offered perspectives on improvements in access to and quality of services for the Malawian population. At the community level, adult male and female clients, as well as youth clients of FHP services, were divided into homogeneous groups for discussions related to their health knowledge, experience of care, and community efforts to create demand and mobilize change. Finally, different types of service providers were interviewed to learn about service delivery to various clients.

The evaluation team conducted 65 KIIs in nine evaluation districts and Lilongwe with representatives of major public and private institutions, communities, and other stakeholders involved in the ONSE Activity. The team also organized 13 FGDs and 11 group interviews (GIs) with district officials and community members in four districts. (For details, see Annex 4, Qualitative Research Activities). Quantitative data was derived from both Activity monitoring data and the Digital Health Information System 2 (DHIS2). The evaluation team employed several methods for qualitative data analysis (e.g., coding and thematic identification and synthesis) and quantitative data analysis (e.g., longitudinal and comparative). Findings were triangulated and used to populate a findings, conclusions, and recommendations matrix. While there were several potential limitations due mainly to the qualitative nature of the data, the evaluation team believes it has mitigated those issues through a variety of analytical techniques and the triangulation of its findings through multiple sources.

KEY FINDINGS

Evaluation Question 1: To what extent did the Activity's interventions achieve their intended results?
Finding 1.1: As measured by achieving its targets throughout the life of the award/activity (LOA), in general ONSE achieved its intended results. However, the results for HSS and increased demand for quality services fell short.
Finding 1.2: The implementation of a single intervention versus a full package created tensions between districts receiving a single intervention (e.g., for malaria) and those receiving larger packages of support.
Finding 1.3: Several foreseen (e.g., similar interventions) and unforeseen (e.g., the COVID-19 pandemic's effects) changes to ONSE implementation affected results.
Evaluation Question 2: To what extent did ONSE improve access to priority high-impact EHP interventions in the target health facilities and community service delivery points?
Finding 2.1: Per key informants, ONSE improved access to priority high-impact EHP interventions; however, whether this finding was significantly different than in non-ONSE districts merits further examination.
Finding 2.2: ONSE's support of health information systems (HIS) contributed to the improvement of EHP service provision at the community level.
Finding 2.3: ONSE conducted numerous well-received HSS interventions to address ongoing issues at the central and district levels. Of note were improvements in supportive supervision, planning, and coordination.
Finding 2.4: Public sector strengthening by the ONSE Activity improved sustainable knowledge and skills among providers delivering services.
Evaluation Question 3: What are the most significant accomplishments, best practices, and lessons learned from the ONSE Activity?
Finding 3.1: Specific, measurable, achievable, realistic, and timed (SMART) capacity building and HSS interventions emerged as the most significant accomplishments of the ONSE Activity. Similarly, HSS interventions were considered among the best practices.
Finding 3.2: While key informants noted many lessons learned, only one (integrated supportive supervision [ISS] and mentorship) stood out.
Finding 3.3: In accomplishing its results, ONSE also experienced a few unintended consequences (e.g., potential changes in gender norms, participant discontent based on the method of payment).
Finding 3.4: ONSE, in collaboration with other relevant stakeholders, relied primarily on the rollout of information systems to monitor the progress of interventions, ensure the reach of services was scaled up and used, and mitigate any challenges to scale-up.
Finding 3.5: While ONSE incorporated measures to ensure greater sustainability of interventions, these did not always align precisely with what key informants believed were either the top factors for ensuring sustainability or factors that may pose risks to long-term adoption of practices.
Finding 3.6: ONSE relied on routine Activity performance indicators to measure and monitor scale-up of activities. However, no defined set of indicators was identified to track quantifiable progress on sustainability efforts.
Finding 3.7: Key informants cited numerous challenges to ONSE's, and there was no clear consensus on which were the most significant. ONSE could have mitigated some of the challenges fully or partially, but others were outside of its manageable interests.
Evaluation Question 4: What were the contextual factors such as socioeconomic factors, gender, demographic factors, environmental characteristics, baseline health conditions, health services characteristics, and so forth that affected implementation and outcomes of the ONSE Activity?
Finding 4.1: There was no one significant contextual factor cited by key informants as facilitating the implementation of ONSE.
Finding 4.2: Key informants cited several contextual factors as having limited ONSE's ability to implement its interventions. The Activity addressed them through responsiveness to changing needs, initiating cost-cutting measures, or fostering greater involvement by community counterparts. However, not all limiting factors could be addressed.
Finding 4.3: Future activities can support the systematic use of data at the facility and community levels in each district to address some of the limiting factors.

CONCLUSIONS

ONSE for the most part achieved its intended results, as demonstrated by the monitoring data analyzed. While there were some shortcomings in certain categories (e.g., HSS and service quality), the Activity met or exceeded most targets. The onset of the COVID-19 pandemic did not appear to substantially reduce the provision of services or achievement of results, pointing to ONSE's ability to adapt interventions to the changed circumstances. While some of its targets may have been affected due to the redirection of funding for COVID-19 and other unforeseen events, it appears to have successfully navigated most of those challenges.

Examining solely the monitoring indicators focused on EHP, it can be concluded that ONSE substantially improved access to EHP services. Per key informant feedback, what appears to have had the greatest effect in improving EHP services provision were interventions aimed at HSS, notably improvements in supportive supervision, planning, and coordination, and efforts to strengthen HIS and use of data for decision-making. By using the SMART[5] capacity building approach, ONSE enhanced overall systemic capacity within the health sector at various geographic levels and improved the performance of individuals, teams, and structures working in and with Malawi's health system. What should be considered and examined moving forward, though, is whether these EHP improvements were significantly better in ONSE districts than non-ONSE districts as the (limited) data analysis around the issue for this evaluation was inconclusive.

Stakeholders indicated that ONSE's HSS interventions were its most significant accomplishment, along with emerging best practices. They also noted that the SMART capacity building approach was a notable achievement of the Activity. It can reasonably be concluded that future approaches to improving the health of Malawians (whether funded externally or domestically) should give serious consideration to incorporating a comprehensive design and hands-on methods for improving health services. Of particular note was the main lesson learned from ONSE: ISS and mentorship leads to improved skills in all service areas. While ONSE tracked the progress and scale-up of its interventions, primarily through the rollout of information systems and use of data, and incorporated measures to better ensure sustainability, these efforts could have been improved.

ONSE, like any other activity, faced numerous challenges in its implementation, both within and outside of its manageable interests. Mitigation measures only partially addresses most of the manageable challenges. Although ONSE both addressed and measured a number of contextual factors related to its implementation, per key informants, no one conclusive factor aided its success. Several elements of a generally enabling environment point to the need to ensure that these types of elements are in place for successful implementation. Respondents were more specific and provided a greater number of responses noting contextual factors that impeded ONSE's implementation. Most of those factors were either somewhat or wholly outside of ONSE's manageable interests or related to unforeseen events (e.g., the COVID-19 pandemic). Thus, while it is commendable that ONSE achieved a substantial portion of its intended results despite these challenges, there remain possibilities for improvement and recommendations for future activities and interventions.

[5] The SMART approach acknowledges that practitioners are critical to effective management and that providing them with tools to collect, analyze, and use information is important, but not enough by itself. Thus, SMART provides comprehensive and ongoing training and support in addition to the tools.

RECOMMENDATIONS IN BRIEF

Because the performance evaluation was conducted at the end of the ONSE Activity, the recommendations below are directed at future activities. They are based on the findings and are divided into those that should be considered high priority and others that are for consideration. Finally, because external funding should be used to support Malawi's Health Sector Strategic Plan (HSSP), in general the recommendations are aimed at all interested stakeholders. Where possible, the evaluation team provides guidance as to which stakeholders should, perhaps, be the primary leads.

HIGH PRIORITY

1. Adopt **an integrated HSS approach**, giving priority to three specific building blocks (health workforce development, particularly supportive supervision and mentoring; support to HIS; and strengthening of the procurement and supply chain management systems).

   Lead stakeholders: USAID and the MOH equally.

2. Continue to use the **SMART capacity building approach** when appropriate.

   Lead stakeholders: USAID and its IPs primarily; potentially the MOH.

3. Conduct initial **harmonized health facility assessments** to ensure participating health facilities are fit for purpose.

   Lead stakeholders: USAID and development partners primarily; potentially the MOH.

4. Continue to **engage with communities,** particularly around issues of mutual accountability for the quality of health services while **non-financially incentivizing** members for their participation.

   Lead stakeholders: USAID and MOH equally.

5. **Define sustainability** prior to implementing interventions and build it into any future activities.

   Lead stakeholders: USAID and development partners primarily; potentially the MOH.

FOR CONSIDERATION

6. Build into the planning and programming documentation **contingency plans** to enable pivots, if needed, to respond to unforeseen events.

   Lead stakeholders: USAID; potentially the MOH.

7. **Delineate** between all partners areas of manageable interest and **lines of accountability**.

   Lead stakeholders: USAID and MOH equally.

8. **Communicate early and widely**, and describe the reasoning for any differentiation in support that will be provided.

   Lead stakeholders: USAID and MOH equally.

9. If resources are available, conduct an **impact evaluation** for any *future* activity that can also include any possible spillover effects.

   Lead stakeholders: USAID and development partners primarily; potentially the MOH.

1. EVALUATION PURPOSE AND EVALUATION QUESTIONS

1.1. ASSIGNMENT PURPOSE

The endline performance evaluation of ONSE aimed to assess the extent to which the Activity achieved its objectives regarding the quality of and access to care, provide in-depth insights into the factors facilitating and limiting increased service utilization at each level of service delivery, and document progress toward building GOM capacity to deliver quality health services.

The findings of this evaluation will inform MOH, USAID, and other development partners regarding the design and prioritization of future investments in strengthening Malawi's health system and supporting the adaptation of current activities where possible. USAID will also use this evaluation to learn whether and to what extent ONSE met the stated objectives of improved access to and quality of a broad range of services (e.g., MCHN, FP/RH, malaria, and WASH); strengthened district health systems in support of these services; and increased community demand for them. The evaluation will also provide in-depth insights into the facilitating and limiting factors of increased service utilization at each level of service delivery. USAID will also use this evaluation to identify activities that warrant continued investment and any additional recommendations to strengthen future program implementation.

1.2. ASSIGNMENT QUESTIONS

The evaluation considered four broad themes: effectiveness, access, quality, and demand. To do so, the evaluation team assessed four main evaluation questions (see Table 1). The evaluation questions are further divided into sub-questions to help answer the main questions.

Table 1: Evaluation questions and sub-questions

Evaluation Questions	Sub-questions
1. To what extent did the Activity's interventions achieve their intended results?	1a. What changes, if any, were made to activities, and how did those changes positively or negatively affect the Activity's achievement of its results?
2. To what extent did ONSE improve access to priority high-impact EHP interventions in the target health facilities and community service delivery points?	2a. Of the capacity strengthening approaches employed by ONSE, which have most enabled the MOH to address systems-level issues at central and district levels?
3. What are the most significant accomplishments, best practices, and lessons learned from the ONSE Activity?	3a. How were these best practices systematically scaled up?
	3b. What strategies, approaches, or methodologies did the Activity use to ensure sustainability?
	3c. How were scale-up activities monitored and measured, and what level of sustainability was achieved?
	3d. What were the challenges faced and how were they addressed/overcome?
4. What were the contextual factors such as socioeconomic factors, gender, demographic factors, environmental characteristics, baseline health conditions, health services characteristics, and so forth that affected implementation and outcomes of the ONSE Activity?	4a. What key findings emerged?
	4b. What were the challenges faced and how were they overcome?
	4c. What more can be done in future projects of similar nature?

1.3. ASSIGNMENT AUDIENCE

The target audiences for the ONSE Activity performance evaluation include:

- The USAID/Malawi Mission;
- GOM MOH units involved in prevention and care services at all levels;
- Collaborators/partners and donors;
- Health care providers, managers, and beneficiaries (including clients and community members and representatives) at the country level; and
- ONSE Activity staff and IPs.

2. BACKGROUND

The MOH of the GOM, despite making progress over the last decades in several areas of MCHN and FP, continued to face many challenges in meeting the Millennium Development Goals (now known as the Sustainable Development Goals). These included low immunization rates, high MMRs, adolescent pregnancies, endemic malaria, gaps in nutrition coverage, and diseases such as diarrhea and respiratory infections. In 2014, USAID's Health Office developed integrated health activity strategies to support Malawi's Country Development Cooperation Strategy. The goal was to support the improvement of Malawians' quality of life by enabling them to access and use those services in a joint and complementary way. A request for proposals was developed for the ONSE Activity.

The overall purpose of ONSE is to reduce maternal, newborn, and child morbidity and mortality. USAID expected this result to be achieved through close coordination with the MOH and other stakeholders to achieve four key intermediate results (IRs):

1. Improved access to priority health services;
2. Improved quality of priority health services;
3. Strengthened performance of health systems; and
4. Increased demand for priority health services.

In addition, because of the unexpected onset of the COVID-19 pandemic, ONSE added the provision of specific support to Malawi's response—in particular, in the 16 districts where ONSE was implemented.

To improve access to high-quality EHP services and improve competence and performance, ONSE adopted an innovative way to build competence and capacity among health and related staff. Rather than traditional classroom-type training, ONSE focused on using the SMART approach to capacity building, along with more sustainable methods such as guided simulation responses, mentoring, coaching, and on-the-job ISS. To meet those objectives, ONSE focused providing technical assistance rather than relying only on direct delivery of services. This required working on the system of governance, leadership, and service management, necessitating close coordination and collaboration with government actors from the central and district levels, as well as related partners and stakeholders. Finally, ONSE worked with communities, not only to mobilize demand and change health-seeking behavior, but also to engage with community leaders and members to self-identify their health and environmental conditions and demand the health system's accountability for the availability and quality of services.

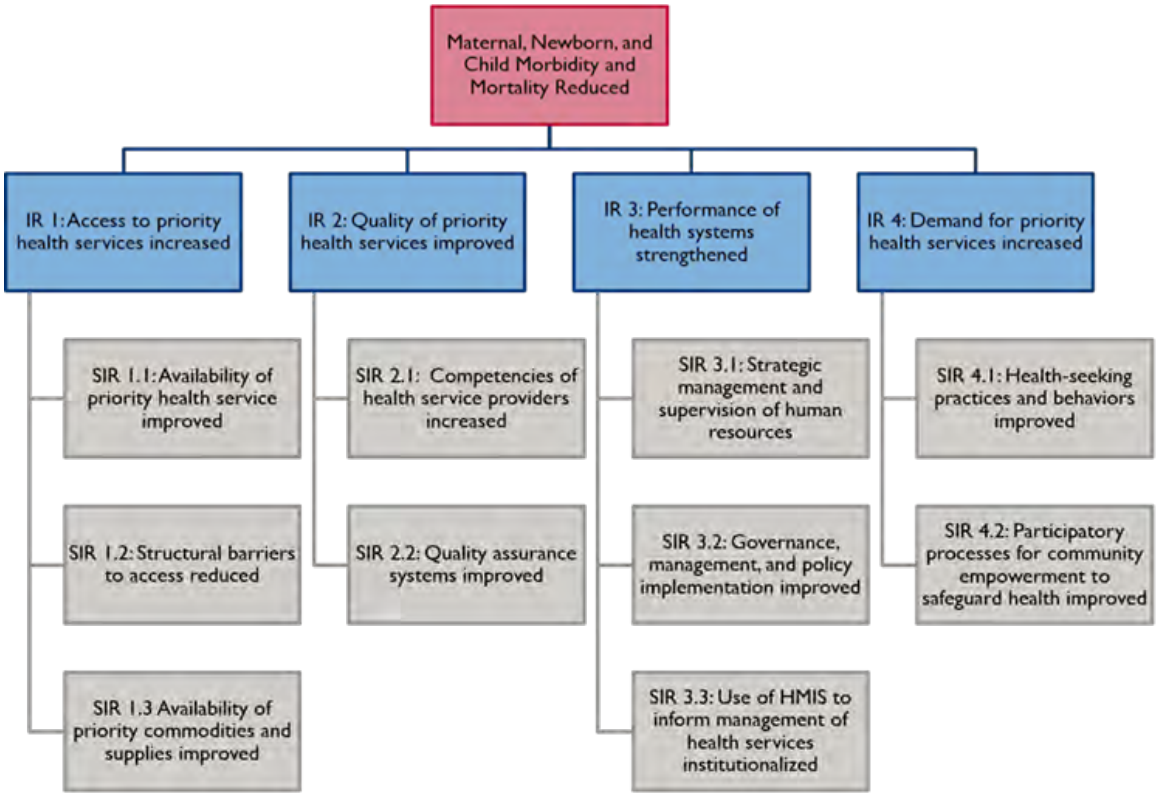
During the final years of implementation, ONSE experienced several changes in its activities and finances, as well as occurrences in the national context. Two changes were a no-cost extension from January to June 2021 and a cost extension from July 2021 to the end of June 2022. Another was the COVID-19 pandemic, which brought several challenges to and changes in implementation procedures. This evaluation considered all major shifts and changes to explore and measure their effects on processes and achievements or results.

2.1. RESULTS FRAMEWORK

ONSE's results framework (Figure 1) presents the four IRs leading to the main result, *Maternal, Newborn, and Child Morbidity and Mortality Reduced.* The IRs complement each other to ensure both increased access to the priority health services targeted in the Activity and the delivery of those services with improved quality of care. Additionally, to achieve and sustain such results, ONSE embarked on a number of key activities to strengthen Malawi's health system. Finally, the Activity aimed to empower clients and

communities and integrate them into the Activity's efforts to increase demand for such priority health services.

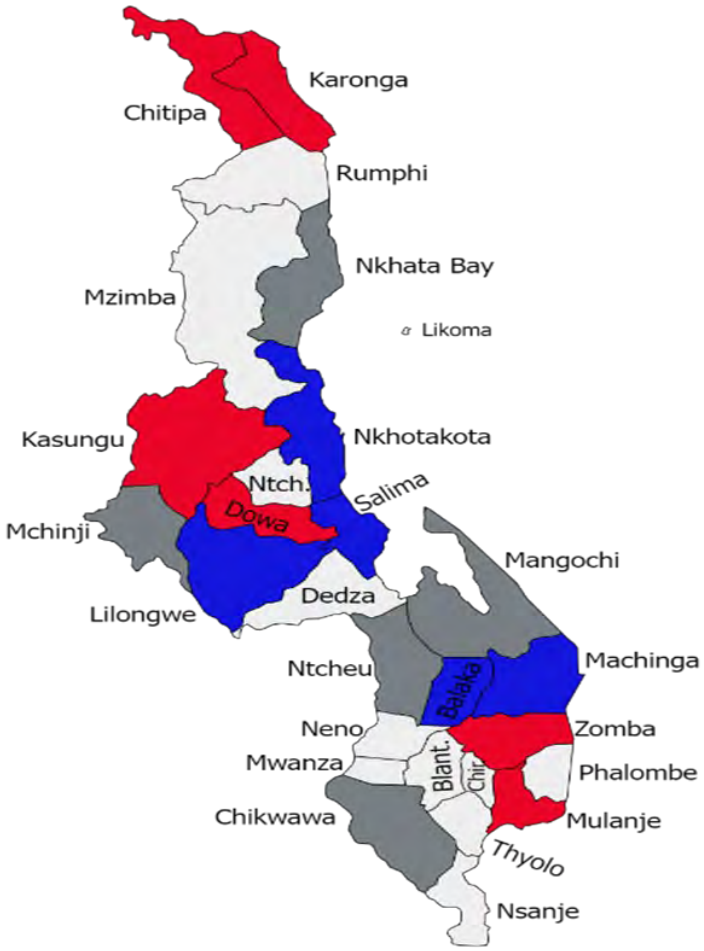
Figure 1: ONSE Results Framework



2.2. GEOGRAPHIC COVERAGE

ONSE conducted activities in 16 districts: Balaka, Chikwawa, Chitipa, Dowa, Karonga, Kasungu, Lilongwe, Machinga, Mangochi, Mchinji, Mulanje, Nkhata Bay, Nkhotakota, Ntcheu, Salima, and Zomba. As shown in Figure 2, intervention strategies varied by district. Malaria interventions were not included in the cost extension period from July 1, 2021, to June 30, 2022.

Figure 2: Map of ONSE Interventions



Legend: Package of Services

		Packages		
		Full	Family Health	Malaria
Services	Family Health*	Blue	Red	White
	Malaria	Blue	White	Grey
	Health Systems Strengthening	Blue	Red	Grey

*Maternal, newborn and child health; FP/RH; nutrition; WASH

3. METHODS AND LIMITATIONS

3.1. METHODOLOGY

This section describes the overall evaluation approach, along with the evaluation questions and sub-questions and evaluation methods. All GH EvaLS assignments follow the GH EvaLS Data Management Plan. The plan details the process for data collection and reporting; data storage and security; data privacy; data flow; data analysis and dissemination; and reviewing and ensuring data quality, as well as posting data to the Development Data Library.

The evaluation used a mixed methods approach to collect data, given that activities were conducted at different levels and in an expanded sequence for nearly six years. The collection of quantitative and qualitative data ensured that the evaluation could answer questions regarding not only access to health care by clients and communities, but also the quality of care and the strengthening of the capacity of health personnel and facilities to provide such care.

3.2. DATA SOURCES

The evaluation methods and data sources depended on the evaluation questions. Qualitative data sources included KIIs, FGDs, and GIs conducted at multiple levels of implementation (national, regional, district, community, and health facility). Sources of quantitative data included a document review, including monitoring data and LOA results, along with some limited analysis of data from the Malawi DHIS2. The data collection approach was inductive to enable the evaluation to delve into complex topics while obtaining multiple perspectives on Activity strategies and interventions.

3.2.1. Document and Desk Review

The evaluation team conducted a desk review to contribute to a thorough understanding, analysis, and interpretation of evaluation findings. The information came from a wide range of documents including the original request for proposals, national- and Activity-specific surveys and assessments, monitoring and evaluation plans and work plans, annual and other time-specific reports, organizational charts, management information systems, and other generic or specific Activity-related reports. Annex 3 is the list of the documents reviewed. The evaluation team used this information to identify key themes for KII and FGD questions. The desk review provided information concerning ONSE's intended and actual implementation efforts as well as its documented achievements and challenges.

3.2.2. KIIs, GIs, and FGDs

This evaluation employed purposive sampling to select evaluation participants. Purposive sampling is widely used in qualitative research for the identification and selection of information-rich cases.[6] The evaluation team identified and selected individuals and groups with firsthand, expert knowledge of the Activity at the central, regional, and community levels. Based on this sampling, the team conducted KIIs (i.e., with one individual), GIs (specific questions directed to two or more individuals), or FGDs (facilitated general discussions with groups of individuals).[7]

At the central level, key individuals included USAID representatives, government officials, Activity staff, key partners, and other development actors. The evaluation team interviewed these participants to 1) discuss and, where possible, validate Activity approaches, interventions, and achievements; 2) elicit

[6] Patton, M. Q. (2002). Qualitative research & evaluation methods (3rd ed.). Thousand Oaks, CA: Sage.
[7] Group discussions or interviews were envisioned as more efficient in obtaining similar or overlapping Activity implementation information from staff with different roles and responsibilities.

opinions and perceptions of the effectiveness of Activity implementation and missed opportunities, if any; 3) obtain firsthand reports on training, supportive supervision, and data and management systems; 4) determine how stakeholders and beneficiaries interacted with the Activity in terms of accountability, partnership, and collaboration; and 5) determine how ONSE contributed to increased uptake of quality health services and behaviors in nearby and hard-to-reach rural communities.

Representatives of GOM ministries provided perspectives on collaboration among bilateral agencies and coordination between central and district public entities during Activity implementation. ONSE's implementing organizations played essential roles in describing Activity implementation successes, challenges, and recommendations for sustained positive outcomes. IPs added clarity to the evaluation team's understanding of information from the desk review. Other agency representatives working in maternal and neonatal health, FHP, supply chain management, and related areas were interviewed concerning coordination and leveraging efforts to reduce duplication. Finally, USAID staff described Activity implementation rollout and results relative to USAID's Country Development Cooperation Strategy and its vision.

At the district level, public sector officers and representatives provided insights into HSS efforts, including supply chain systems and the SMART capacity building strategy. This was especially important as much of the district planning and decision-making occurred at this level, because the government has undergone a decentralization process in recent years. Health service providers from the public and private sectors were interviewed regarding training and other support received from ONSE and on their perspectives on improvements to access and quality of services for Malawians. The evaluation team made efforts to understand differences in the types of district-level staff from ONSE implementing organizations as crucial key informants to explain how the Activity provided supportive supervision and coordination during the LOA. Finally, the evaluation team interviewed local stakeholders[8] whose activities influenced ONSE.

At the community level, clients of FHP services were separated into homogeneous groups (male, female, and youth) for discussions related to their health knowledge, care service experiences, and community efforts to create demand and mobilize change (e.g., community champions). The evaluation team worked with implementing organizations to find youth who took part in intervention activities to assess their viewpoints during FGDs. IPs also assisted in finding health volunteers to understand demand creation at the community level. Finally, the evaluation team interviewed different types of service providers to learn about service delivery to varied districts and clients. Table 2 lists the estimated evaluation sampling numbers for FGDs and KIIs. Annex 2 presents data collection tools, and Annex 4 provides details of the final evaluation participant groups, geographic breakdown of participants, and the domains of inquiry.

Table 2: Evaluation sampling for KIIs, FGDs, and GIs

Data Collection Level	Method	Number
Central Level		
MOH and other public representatives	KIIs	4
USAID	KIIs	2
Prime IP	KIIs	5
Other IPs	KIIs	4

[8] Including district health officials and officers, health providers, community leaders, health volunteers, and adult and youth recipients of ONSE services.

Data Collection Level	Method	Number
Other development partners	KIIs	2
Total (all KIIs)		**17**
District Level*, ** and Lilongwe		
.	KIIs	48
	FGD participants	13
	GI participants	11
Total participants (all methods) at the district level		**72**
Total number of individuals participating		**89**

***** This included district health officials and officers, health providers, community leaders, health volunteers, adult and youth clients of services.
****** The districts were Balaka, Chikwawa, Chitipa, Karonga, Kasungu, (Lilongwe), Machinga, Nkhata Bay, Nkhotakota, and Ntcheu.

The evaluation team coordinated with the prime IP, MSH, to plan practical and smooth data collection activities with evaluation participants at the district and community levels. A team of local consultants worked in pairs to conduct KIIs and GIs and take notes. The field notes were then completed and transcribed for analysis. The core evaluation team and field team used WhatsApp for daily check-ins and weekly debriefings on data collection status, observations, and findings.

3.3. SITE AND SAMPLE SELECTION

Given the anticipated evaluation timeframe, the evaluation team, in collaboration with USAID/Malawi, selected nine districts and the capital city, Lilongwe, for the endline performance evaluation. The selection of sampling sites took into account the types of intervention packages (full versus single intervention package), geographic areas (Northern, Central, and Southern districts), as well as the presence of the Christian Health Association of Malawi as a key partner. The team also coordinated the selection of smaller geographic zones (villages) with MSH to complete the sample and include hard-to-reach intervention areas. The nine districts sampled were Balaka, Chikwawa, Chitipa, Karonga, Kasungu, Machinga, Nkhata Bay, Nkhotakota, and Ntcheu, along with Lilongwe. Although the findings may not necessarily be generalized to the rest of the country, the diverse types of respondents and study sites should inspire some confidence that the results reflect the typical experience in rest of the ONSE districts.

4. DATA ANALYSIS

To answer the evaluation questions, the evaluation team cross-referenced information obtained during the desk review with primary data (interview and group discussion data) and quantitative analysis to develop conclusions and recommendations. The team used multiple quantitative and qualitative methods, and existing data (Activity performance indicator data, etc.) to triangulate findings and produce more robust evaluation results.

The team reviewed KII, GI, and FGD transcripts and organized responses to align with the evaluation questions, prevalent themes, and perspectives. They also cross-checked responses to verify data. This facilitated the transition to the interpretative phase to support the development of evidence to reflect emerging themes. The team used the resulting qualitative data to corroborate and triangulate performance indicators, gaining further insights and clarifying the narrative behind the quantitative data.

Quantitative data analysis used existing service performance indicator data extracted from districts, facilities, community health management information system (HMIS), Activity-developed data tools, and data compiled in the Activity Monitoring and Evaluation Plan (AMEP) LOA indicators from the Final Activity Report (see Annex 5). This quantitative data reflecting the extent of Activity service indicators achieved is presented in simple cross-tabulations and service targets achievement levels, as well as IR-related bar charts for visualization. The data validated access to and use of services at the public and private institutional levels, including aspects of coverage of MCHN, youth-friendly health services (YFHS), post-abortion care, intermittent preventive treatment in pregnancy, WASH, and malaria care demand and uptake, as well as HSS activities at the central and district levels. Additionally, using two data sets derived from the DHIS2, the evaluation team performed longitudinal and comparative analysis for a limited number of indicators. The team used the quantitative data to corroborate findings from the qualitative data, which was the primary source of analysis.

The evaluation team used NVIVO software to analyze qualitative data for the ONSE performance evaluation. The data analysis entailed setting up an analysis project file in the software, defining primary or main themes (parent nodes) as reflected in evaluation questions, importing interview transcripts (data sources) into the project, reading through transcripts and identifying sub-themes (child nodes), and coding each theme. Each theme was developed or coded to pre-defined precise levels for better insight into the qualitative data and findings. The team coded 75 transcripts[9] in NVIVO. Upon completion of the coding, themes (codes) were expanded, and the list was exported to a Microsoft Excel spreadsheet summarizing the number of data sources (files or transcripts) reporting on a given theme and the number of references or direct quotes per each specific theme.

Qualitative analysis summary tables were extracted from the Excel spreadsheet for easy sorting according to a number of data sources and references. This was intended to identify themes that involved a large number of interviews (informants). It also enabled the extraction of corresponding references (direct quotes) by theme. Emerging themes were synthesized to gauge how different themes linked to one another. Where themes were related, they were merged into a broad theme or finding during report writing. The direct quotes were read and key messages identified and reported either independently (standalone findings) or jointly with quantitative findings. A selection of direct quotes in the report gives voice to evaluation participants and validates synthesized findings.

[9] This is fewer than the number of participants, as each FGD and GI resulted in only one transcript.

5. ETHICAL CONSIDERATIONS

5.1. HUMAN SUBJECT PROTECTION

The evaluation team developed protocols to ensure privacy and confidentiality during data collection. Primary data collection included a consent process that described the purpose of the assignment; risks and benefits to participants and communities; the right to refuse to answer any question; and the right to refuse to participate in the assignment at any time, without consequences. Only adults could consent as part of this assignment. Youths recruited for the evaluation were at least 18 years of age. During the evaluation process, if data from existing documents included unique identifiers, those data were abstracted without including the identifying information. The data collectors sought and obtained verbal consent prior to data collection. All data collectors were trained in informed consent.

6. LIMITATIONS

The evaluation team anticipated that it would need to mitigate several possible biases and other data limitations through methodological and/or analytical means.

6.1. RELIABILITY AND VALIDITY

This evaluation employed qualitative data methods to complement existing quantitative data. Qualitative methods, by their nature, are less structured than quantitative methods to allow for greater exploration and depth in answers. As such, data quality depends on the data collector rather than quantitative or structured survey tools. To help ensure the reliability and validity of qualitative data, local data collectors underwent remote training to learn or refresh data collection techniques and become familiar with the evaluation tools. The evaluation team and data collectors conducted regular debriefs to help ensure the reliability and validity of the qualitative data.

6.2. QUALITATIVE APPROACH

The primary approach for this evaluation was qualitative data collection via KIIs and FGDs and, to a lesser degree, the review and analysis of secondary qualitative and quantitative data. The opinions of stakeholders are, by their nature, subjective, and may reflect certain vested interests. Further, team members may not have accurately recorded or correctly transcribed important data for a variety of reasons (such as fatigue and difference in understanding). Therefore, the team instituted data checks that were both internal (e.g., team members cross-checking each other's notes) and external (e.g., triangulating among various data sources) to mitigate this issue as much as possible.

6.3. QUANTITATIVE DATA FROM PROJECT REPORTING

The evaluators conducted secondary analysis of the quantitative data collected and reported to USAID through project performance indicators. The integrity and quality of project data reported was assumed. Additionally, the team performed limited analysis of data supplied via DHIS2. The analysis and results, when presented, involve a number of assumptions and caveats that are noted.

6.4. SELECTION AND REPRESENTATION BIASES

The evaluation team identified a large and diverse group of stakeholders at the central and peripheral levels. It is possible that some key stakeholders may have been excluded inadvertently and that some participants in KIIs, FGDs, or GIs may have introduced self-selection bias (either beneficial or detrimental) into the results. Persons with stronger vested interests in the results of the assessment (either negative or positive) may have been willing to spend more time with the interviewers. As a result, it may not have been possible to obtain a complete representation of all stakeholders, although the team believes that this was at least partially mitigated by the broad extent of those interviewed (see Table 2).

6.5. RESPONSE BIAS

Response bias is a common problem for assessments, evaluations, and reviews that takes several forms. For instance, respondents may make positive remarks to interviewers about an activity because they have a vested interest in seeing it succeed and continue. Respondents may be inclined to shape their responses according to gender or other social norms, or to say what they think an interviewer wants to hear. The team anticipated this possible bias and took several measures to mitigate the issue. Those measures included similar but not identical questions throughout interviews; carefully reviewing the wording of questions to ensure that language was culturally appropriate and did not include any inherently biased wording; and providing open-ended questions, including the option not to respond.

6.6. EVALUATION SUBSEQUENT TO PROJECT CLOSE

As the ONSE Activity ended before the evaluation process began, there were additional limitations to Activity data resources and staff available to further define, triangulate, and validate qualitative and quantitative data or details of Activity successes and challenges.

The evaluation team mitigated some of the limitations described above through a combination of thorough training of interviewers; consistent development and pilot testing of tools; consistent fieldwork supervision, including sample reviews of first transcripts to ensure comprehensive questioning and accurate notetaking during interviews; and triangulation of methods from different and complementary sources of data. Transcription errors were reduced through joint reviews of field notes among the team, especially at the start of fieldwork, to seek internal agreement and clarify any questionable or conflicting notes. These measures were intended to reduce the appearance and subsistence of biases and limitations, rendering more complete and valid data collection and results.

7. FINDINGS

This section presents the key findings of the endline performance evaluation based on the four evaluation questions and corresponding sub-questions.

7.1. EVALUATION QUESTION 1

To what extent did the Activity's interventions achieve their intended results?

1a: What changes, if any, were made to activities, and how did those changes positively or negatively affect the Activity's achievement of its results (e.g., gaps and opportunities in retention and training of health workers)?

Finding 1.1: As measured by achieving its targets throughout the life of the Activity, in general, ONSE achieved its intended results; however, the results for HSS and increased demand for quality services fell short.

> *"Through the ONSE Activity, these funds helped fill a large gap in the health sector and made it possible for district councils to deliver essential health services … It enabled improvement in a number of areas, including equitable access and quality health care services."* —Key informant

As shown in Table 3, several IRs were achieved wholly (e.g., integration of interventions) or substantially (e.g., quality of priority health services, and cross-cutting interventions), or had reasonable success (e.g., increasing access to priority health services). Where ONSE fell short was in improving the performance of the health system and increasing demand for quality priority health services. Further details of specific interventions, their actual results, and targets are provided in Annex 5.

The impact of the COVID-19 pandemic must be accounted for within the life of ONSE—specifically, whether it affected implementation of interventions during the period 2020–2022. Therefore, the evaluation team conducted additional analysis using DHIS2 data to examine whether the effects of COVID-19 were noticeable for a limited number of interventions within the 16 ONSE districts. Those results are depicted in Figures 4–7. As noted, except for the provision of oxytocin, which may have been due to supply chain issues early in the pandemic, no other indicators showed declines and, indeed, most showed consistent improvement.

Table 3: Indicator performance success rate by ONSE intermediate results

ONSE Intermediate Result	Total # of Performance Indicators	# of Indicators with LOA Target 90%+ Achieved	# of Indicators with LOA Target <90% Achieved	% of Indicators with LOA Target Achieved at 90%+ (Success Rate)
IR 1: Access to priority health services increased	39	28	11	72%
IR 2: Quality of priority health services improved	6	5	1	83%*
IR 3: Demand for quality priority health services increased	8	4	4	50%
IN-1: Number of integration interventions completed	1	1	0	100%
Cross-cutting indicators	4	3	1	75%

**Data for five training indicators not included for IR 2 as LOA data was not available to evaluators. This may affect the overall success rate for IR 2.*

Figure 3: Provision of Oxytocin for Emergency Obstetric Care

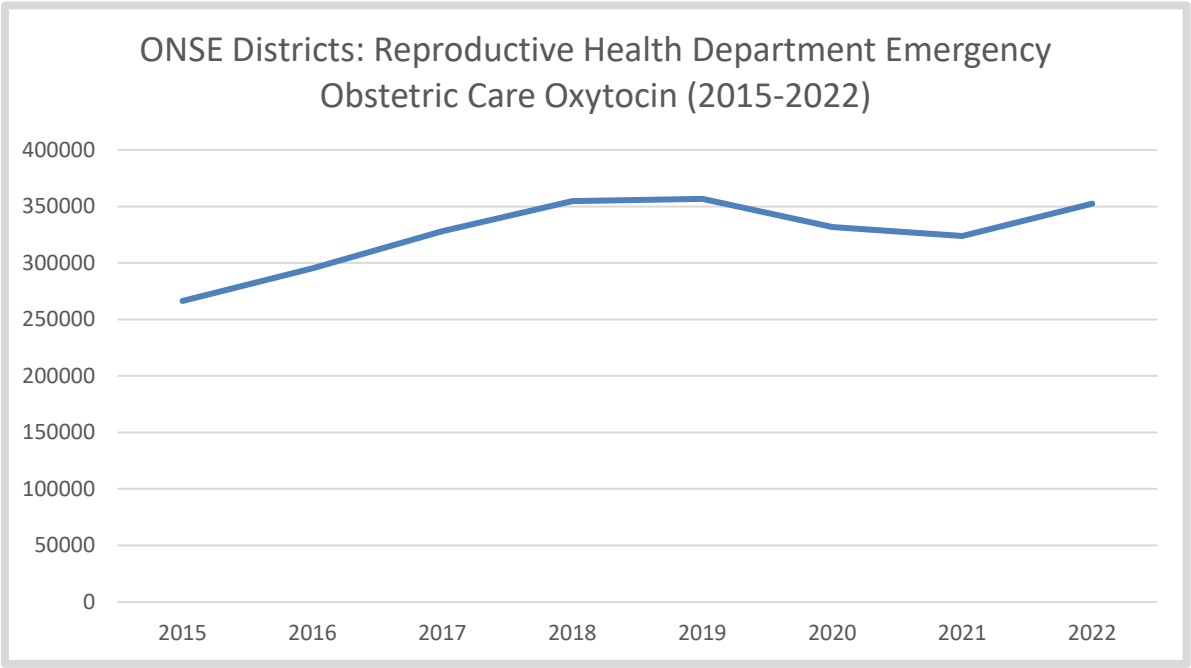
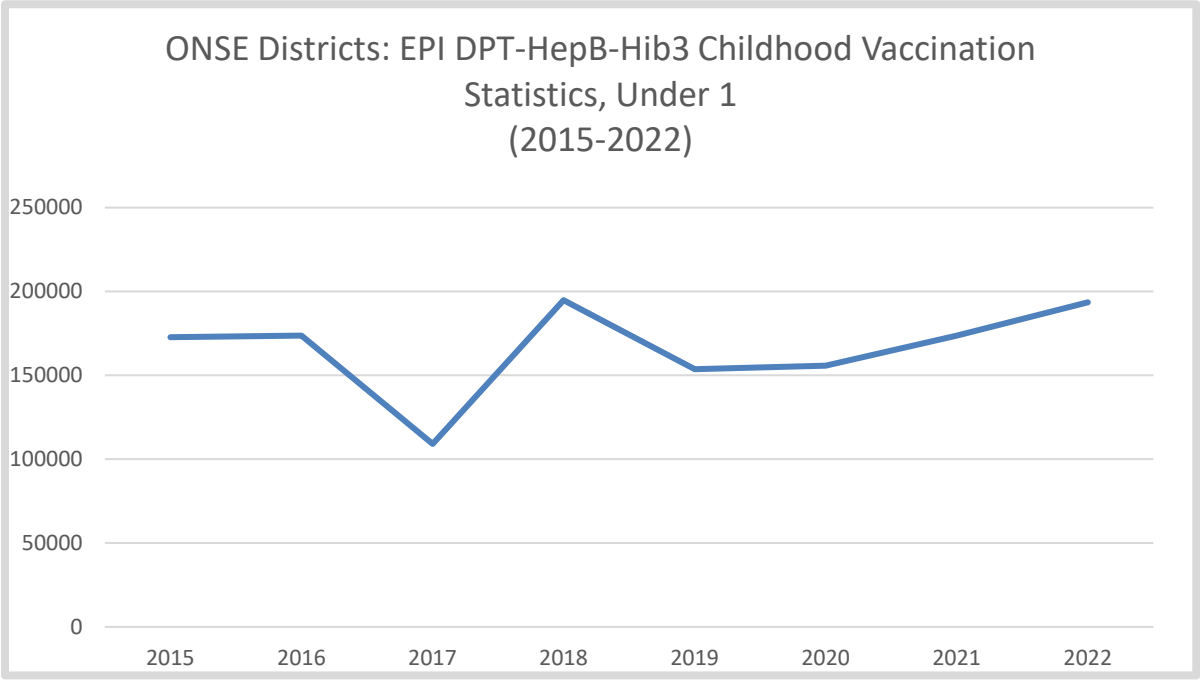


Figure 4: Under-1 Childhood Vaccinations



** Data for two districts (Lilongwe and Ntcheu) are missing for 2017, accounting for the decline.*

Figure 5: Women Making More than Five ANC Visits

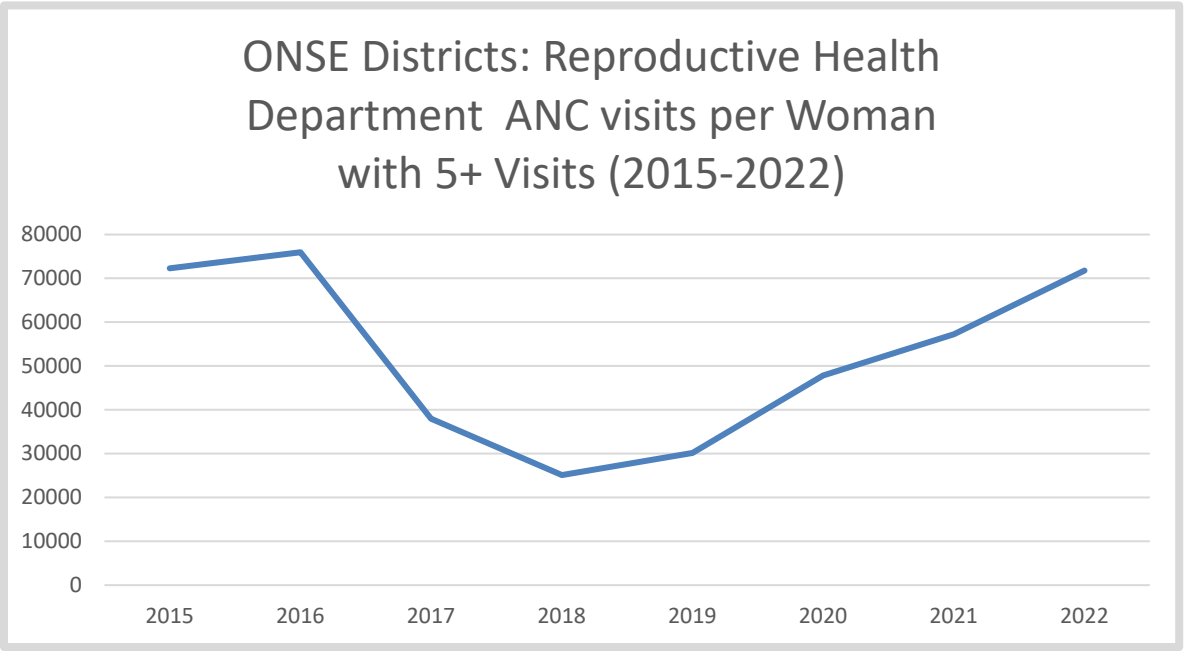
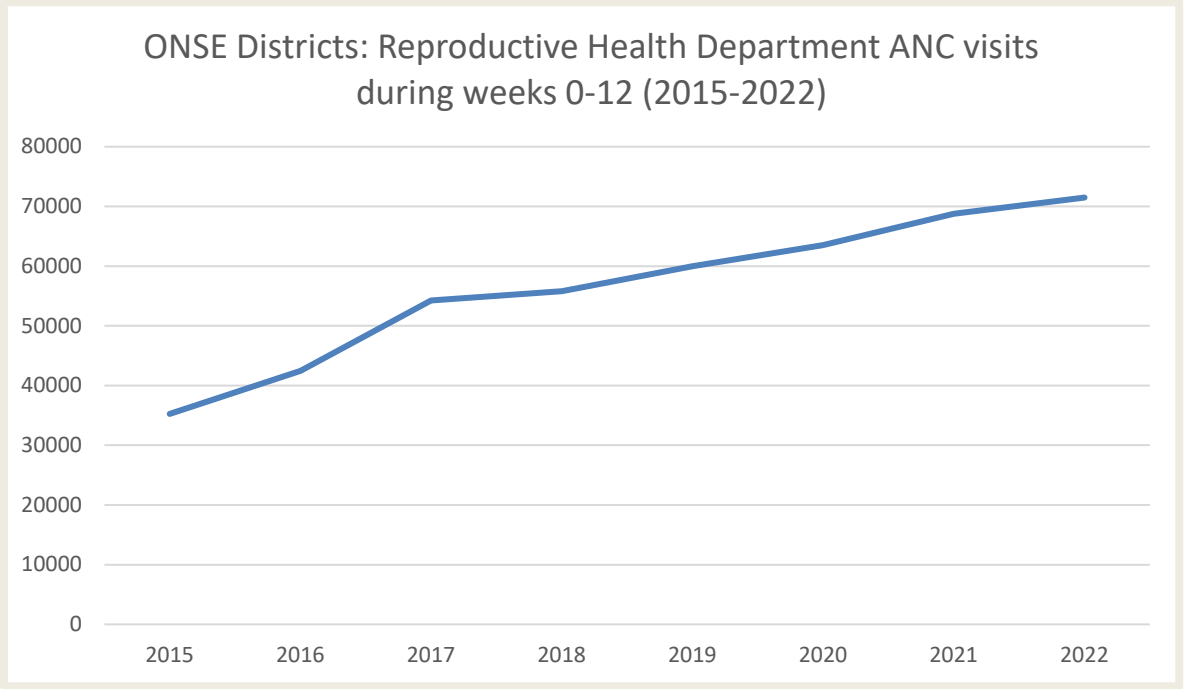


Figure 6: Early ANC Visits



Key informants reported many reasons for ONSE's achievement of its results. Table 4 lists the most frequently cited interventions, many of which were structured around either improving infrastructure and logistics or increasing access to quality services. The evaluation team observed no consistent feedback in KII responses on interventions that may have negatively affected ONSE's ability to achieve its results (e.g., KII responses did not include enough mentions to be significant).

Table 4: Top Interventions that Contributed Most to ONSE Achieving Its Results (at Least 10 KII Mentions)

Intervention	KII Respondents[10]
Improving infrastructure and medical equipment	27
Increased access to FP services	23
Organized outreach clinics	17
COVID-19 vaccination provision	16
Increasing ANC attendance	14
Logistics support to health facilities	14
Integration of health services	13
Improved quality of MCHN services	12
Logistical support (general)	11
Increased access to WASH services	10
Re-allocation of medical supplies	10

It was, of course, not sufficient for ONSE to increase the supply (and quality) of services to achieve its results; the Activity also had to create demand among potential clients. While respondents mentioned 14 ONSE interventions as increasing demand, only three received more than three KII mentions (see Table 5).

> *"… we were able to support 3.8 million couple-years of protection with the FP services. We resuscitated over 40,000 newborn babies born with difficulties in breathing."*
>
> —Key informant

Table 5: Top Three Interventions that Increased Demand for Health Services per KIIs

Intervention	KII Respondents
Improved sanitation in facilities	11
Increased involvement of community	6
Youth uptake of YFHS	6

Finding 1.2: The implementation of a single intervention versus a full package created tensions between districts receiving a single intervention (e.g., malaria) and those receiving larger packages of support.

Key informants commented that some districts did not understand why ONSE provided them a full package of support, while in other districts it focused solely on malaria. Some respondents noted that this strained the relationships between districts and resulted in suboptimal interactions. In districts that received a single intervention, the general perception was that the Activity's interventions partly achieved their intended results, while its efforts were more recognized and appreciated in districts receiving the full package. Further, as one key informant noted, because ONSE was implementing malaria interventions in the sub-

> *"… malaria interventions were not in all districts. So, where you have inputs on one intervention like malaria, achieving optimal results, you will observe gaps in other districts … Communities were not benefitting for accessing those services. This is where the mismatch has been, and ONSE has left that mark."* —Key informant

[10] "KII Respondents" represents the number of key informants who mentioned a particular intervention at least once during their interview. In other words, a key informant may have mentioned the intervention multiple times throughout the discussion, but it was recorded only once for reporting purposes. This is believed to be a more accurate representation than the number of mentions (e.g., one respondent may have mentioned an intervention several times).

group of districts, those same districts were not included in the most recent Global Fund grant application. This affected them when ONSE's resources became scarcer.

Finding 1.3: Several foreseen and unforeseen changes to the ONSE intervention implementation affected results. Changes that affected ONSE positively and negatively included:

- Widespread power outages during the first year of ONSE diverted funds from planned interventions for the purchase of fuel and generators.
- As early as ONSE's second year, there were important changes in its scope as needs arose to support the MOH in developing its national performance-based finance strategy, conduct contact investigation of tuberculosis cases in Machinga, and support an effective response to an outbreak of cholera.
- In Activity Year 3, the United States government (USG) shutdown put the Activity into temporary slow-down mode.
- During years 4–6, ONSE adapted SMART capacity building approaches to address the impact of the COVID-19 pandemic on the health and safety of ONSE staff and of health workers.
- Key informants noted that overlap with a Canadian-funded program led to duplication of efforts, and discontent among ONSE participants, as the Canadian project paid higher allowances.

7.2. EVALUATION QUESTION 2

To what extent did ONSE improve access to priority high impact EHP[11] interventions in the target health facilities and community service delivery points?

2a: Of the capacity strengthening approaches employed by ONSE, which have most enabled the MOH to address systems-level issues at central and district levels?

Finding 2.1: Per key informants, ONSE improved access to priority high-impact EHP interventions; however, whether this was significantly different than in non-ONSE districts merits further examination.

Given that only 20 percent of the population lives within 25 kilometers of a hospital, ONSE worked with the MOH to increase the proportion of health facilities offering priority EHP services, strengthen existing outreach clinics, establish new ones, and conduct community services campaigns, such as for vaccination and FP, so services were brought closer to the people.

Health facility respondents highlighted ONSE's support as helping to ensure regular and continued supplies of commodities, equipment, and fuel for transportation; data management; and training of providers that were prerequisites for the enhancement of EHP services in health facilities. Respondents noted that this assistance enabled clients to better access vital services. Support by ONSE to organize community outreach clinics was critical in increasing access to EHP services for community beneficiaries by taking services to their doorsteps. ONSE strengthened Community Champions, community health workers, and Community Health Action Group (CHAG) members who played important roles in disseminating information about services and referrals, eventually creating demand for services at

[11] Per the Health Sector Strategic Plan II: 2017–2022, the EHP covers several categories under which there are numerous intervention packages and interventions. The main categories are reproductive, maternal, newborn and child health (RMNCH); vaccine preventable diseases; malaria; integrated management of childhood illnesses; community health; neglected tropical diseases; HIV/AIDS; nutrition; tuberculosis; non-communicable diseases; and oral health. Historically, the EHP has been financially unobtainable and unsustainable.

community-level clinics and health facilities. Table 6 lists the five top interventions that improved the quality of EHP services.

Table 6: Top Five Interventions that Improved the Quality of EHP Services, per KIIs

Integrated supportive supervision at the facility level	31
Social accountability (scorecards)	15
Improved skills of health workers	10
Strengthened management of human resources	7
Improved quality of baby friendly services	5

A cross-section of relevant performance indicators for the provision of EHP reflected gains in the targeted districts over the Activity timeline. six of the seven indicators reached or exceeded their LOA targets (see Table 7). Only 81% percent of pregnant women reached with nutrition interventions underperformed, and only by 19 percent below its LOA target.

Table 7: LOA Changes in Provision of Selected EHP Services

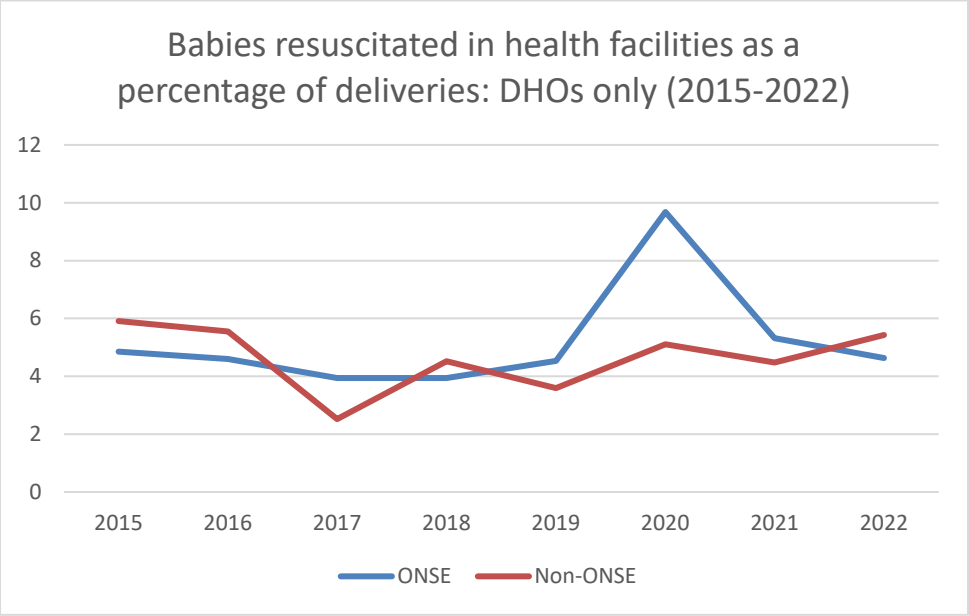
Indicator	Baseline	LOA Target	Endline Result	LOA target Achieved	LOA Change from Baseline
Number of newborns not breathing at birth who were successfully resuscitated in USG supported program	3,500	34,500	49,821	144%	+46,321 newborns (1,324% increase)
Number of pregnant women who initiated ANC visits in the first trimester	36,500	259,730	233,906	90%	+197,406 women (541% increase)
Number of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs (EPMM indicator)	155,000	1,269,00	1,200,068	95%	+1,045,608 women (544% increase)
% of pregnant women reached with nutrition interventions through USG-supported programs	242,000	1,916,800	1,557,978	81%	+1,315,578 women (544% increase)
Number of children who received DPT3 PENTA III by 12 months of age in USG-assisted programs	0	1,070,600	1,155,504	108%	0-> 1,155,504 children
Number of children ages 12–23 months who received measles-rubella second dose via USG-assisted programs	0	599,759	542,672	90%	0-> 542,672 children
% of non-public health facilities (including the Christian Health Association of Malasi, NGOs, and private for-profit institutions) supported by USG to provide priority health service	46%	70%	77%	110%	67% increase

Source: AIDS-612-C-00001 ONSE Final Project Draft 2022

> *"ONSE ensured the availability of a system for tracking stocks of drugs at the health center, which gave timely data required for the ordering the EHP drugs needed … and continually requested reports and provided gadgets for capturing data … which improved the information system."* —Key informant

One final point of analysis was a cursory examination of one of the EHP interventions to see whether there was a significant difference in the performance of the 16 ONSE districts versus the 12 districts in which ONSE was not implemented, as reported by district health offices (DHOs) in the DHIS2. The evaluation team selected data for neonatal resuscitation[12] for this analysis, as it presented a complete data set from all the districts for the period 2015–2022. As shown in Figures 8, 9, and 10, while an overall slightly greater number of resuscitations was performed in ONSE districts, there were no significant differences in those done by bag and mask ventilation versus airway cleaning and stimulation. Indeed, for 2020, when resuscitations increased in ONSE districts, fewer newborns were resuscitated by either method compared to non-ONSE districts. This may be due to supply chain issues in 2020 that marked the onset of the COVID-19 pandemic or other methods used during that year (e.g., dry and wrapping). Regardless, this initial exploration of the data should be further investigated to identify any comparative differences between the ONSE and non-ONSE districts.

Figure 7: Newborns Resuscitated (ONSE Versus Non-ONSE Districts)



[12] Per the Health Sector Strategic Plan II: 2017-2022, neonatal resuscitation is part of the intervention package for deliveries as a sub-group of the RMNCH category.

Figure 8: Newborns Resuscitated via Airway Cleaning and Stimulation (ONSE Versus Non-ONSE Districts)

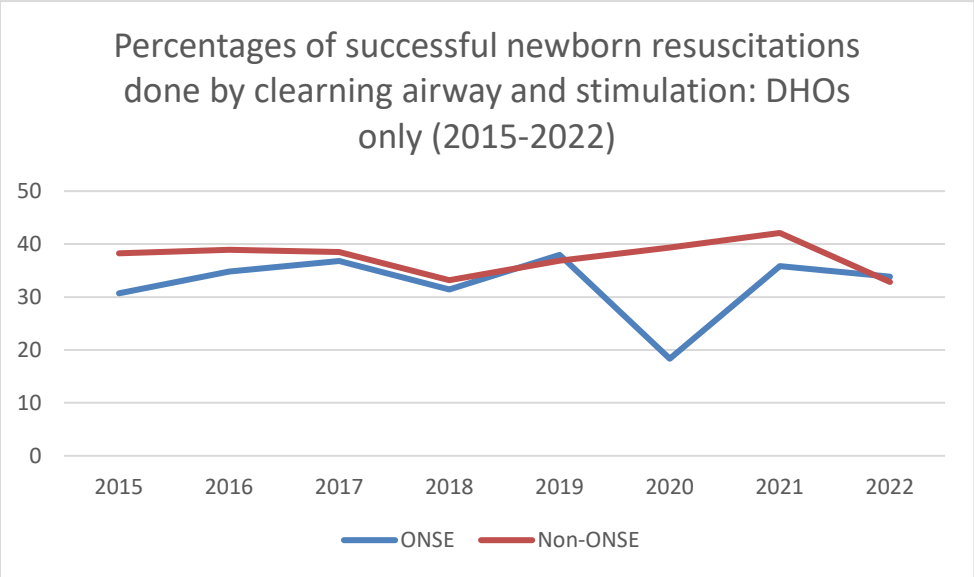
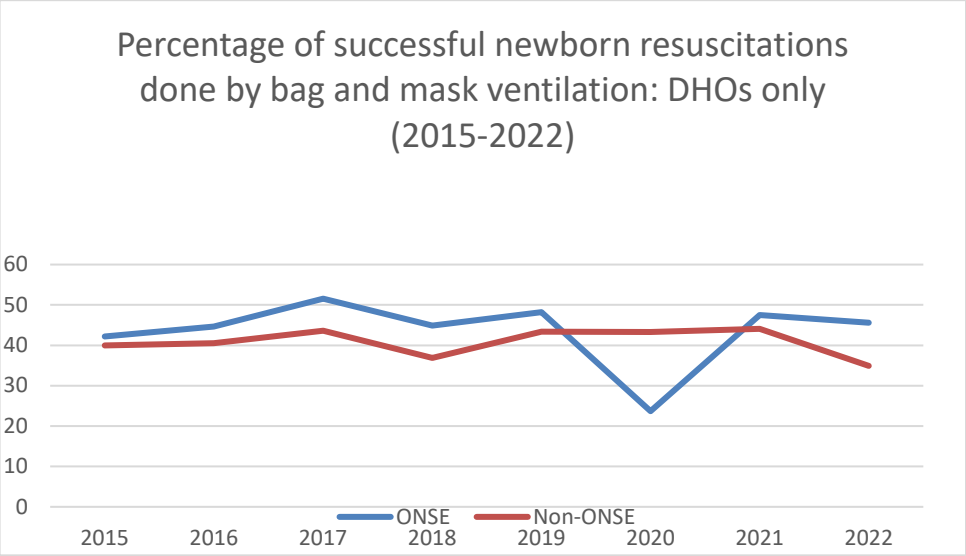


Figure 9: Newborns Resuscitated via Bag and Mask Ventilation (ONSE Versus Non-ONSE Districts)



Finding 2.2: ONSE's support of the HIS contributed to the improvement of EHP service provision at the community level.

Although none of the HIS interventions (see Table 8) met their targets, feedback received by MOH staff at all levels indicated that these interventions were crucial in supporting EHP service provision. Notably, monthly data review meetings provided clinicians and health workers with essential indicators to monitor gaps and shortfalls in health facilities. ONSE also supported public and private sector officials with appropriate capacity building and infrastructure development in HIS. In turn, this assisted these officials to assess the needs of the facility and take essential and appropriate measures to rectify them.

Respondents also appreciated the introduction of the COMCARE tool for supportive supervision and direct feeding of data into the HIS, which led to faster responses by health managers. ONSE also provided health service assistants with tablets to update the DHIS2 database, along with fuel, vehicles, and, on occasion, allowances to facilitate the collection of data at the community level in ONSE-sponsored districts. This improved the quality and timeliness of the data collection and review process. Strengthening the functionality of existing MOH systems at the central and district levels to continue supporting decentralization policies also demonstrated gains as a result of ONSE interventions.

Table 8: Interventions Affecting Systems-Level Issues at the MOH Central and District Levels

Indicator	Baseline	LOA Target	Endline Result	LOA Target Achieved	LOA Change from Baseline
Number of District Implementation Plan (DIP) reviews conducted to revise DIP activities or budgets with stakeholders	16	161	139	86%	+123 DIP reviews (769% increase)
% of health facilities supervised based on performance standards in ISS tools that completed follow-up actions	40%	89%	75%	85%	86% increase
Number of health facilities submitting data in line with national standards (DHIS2)	205	308	307	98%	+102 health facilities (50% increase)
Number of health facilities submitted data in line with national standards (Open logistics management information system [LMIS])	308	388	380	98%	+72 health facilities (23% increase)

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Finding 2.3: ONSE conducted numerous well-received HSS interventions to address ongoing issues at the central and district levels. Of note were improvements in supportive supervision, planning, and coordination.

> *"The monthly data review meetings provided clinicians and other health workers with the required indicators to monitor the gaps and shortfalls in their health facilities. The DHO, GOM, health workers, and other partners now have the necessary infrastructures like the DHIS2 to help them know what each facility needs."* —Key informant

ONSE supported the decentralization model in Malawi, devolving MOH decision-making authority for budgets, planning, and management of health services from the central level to the district level. To do so, the Activity coordinated and funded regular capacity building meetings and provided tablets, community-focused tools and methodologies, and electronic resources in the 16 districts to set and achieve operational agendas in support of high-quality, in-demand health services that prioritized community needs. This was well-received by district and central managers and supported ongoing functionality and productivity during the ONSE Activity timeframe, as well as stronger collaborative relationships with central MOH technical managers and working groups. Of more than 50 beneficial HSS interventions provided by ONSE as noted by key informants, Table 9 lists those that key informants cited most often.

Table 9: Top 10 HSS Contributions by ONSE, per KIIs

Themes	KII Respondents
Supportive supervision	22
Improved planning by districts	21
Improvement in data quality	20
Coordination of the health system	17
Improved health programming	17
Integrated supportive supervision (digital tools)	17
Mentorship of health workers	15
Collecting and analysis of DHIS2 and LMIS data	14
Improved reporting rates	11
Assistance in the implementation of projects at district level	8

> *"ONSE engaged and mobilized communities to disseminate critical health information and messages, increased demand for and utilization of high-quality services, and strengthened and elevated the voices of citizens and communities to ensure that health services are accountable to their users."* —Key informant

To promote a robust systemic capacity building approach, ONSE intervened at multiple levels of Malawi's health system and targeted various components. Many respondents highlighted positive outcomes, from interaction with technical working groups at the central level to the facilitation of district-level planning. A key interviewee pointed out that ONSE's revival of district-level committees and decentralization of supervision and monitoring from the central MOH to the district level contributed to strengthening district-level capacity and efficiency in addressing community health needs. Several respondents underscored ONSE's input to the strengthening of health center management committees, and establishment and revitalization of CHAGs to enhance communities' roles in supporting the implementation of community-led approaches, including the involvement of village health committees. Respondents also expressed appreciation for ONSE's contribution to empowering and building the capacity of community members and service providers to disseminate information on the availability of services and referrals.

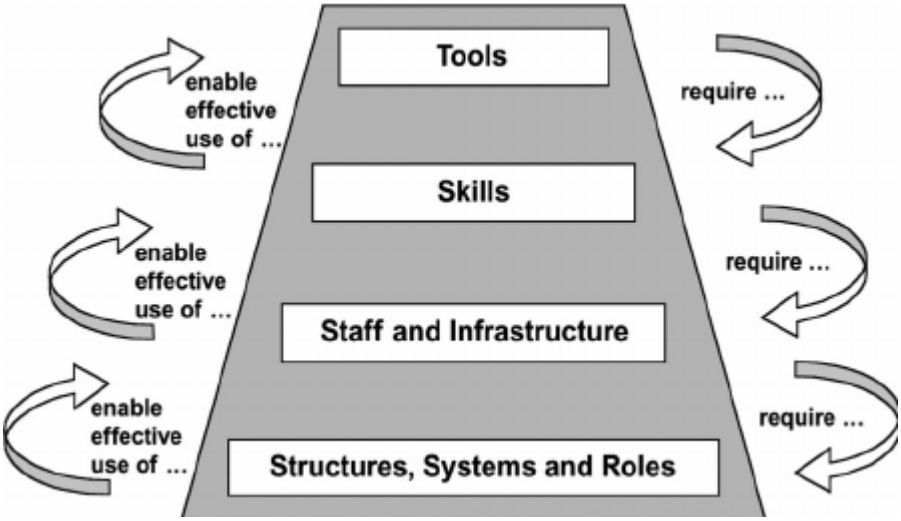
Finding 2.4: Public sector strengthening by the ONSE Activity improved the sustainable knowledge and skills of providers delivering services.

> *"As a provider, the mentorship has helped me to attain much knowledge and skills on how to manage complicated cases or how to deliver the service in general to clients or mothers or patients who come to our facility."* —Key informant

To enable stronger overall systemic capacity, ONSE intervened at multiple levels to improve the performance capacity of individuals, teams, and structures working in and with Malawi's health system. Recognizing that traditional classroom-based training had a limited impact on outcomes, increased workplace absences, and distorted incentives, ONSE catalyzed a shift toward approaches that develop skills in day-to-day working environments through simulation-based practice and drills, coaching, and mentoring based on the SMART capacity building approach first formulated by Potter and Brough (see Figure 11).[13]

[13] https://www.researchgate.net/figure/Capacity-building-pyramid-Potter-and-Brough-7_fig1_264055541

Figure 10: Basic Conceptualization of SMART Capacity Building Approach



Most of the SMART capacity building approaches that ONSE successfully implemented during Years 1–4 relied on face-to-face interaction and on-the-job skills building to drive change. With the onset of the COVID-19 pandemic in 2020, ONSE recognized the need to strategically adjust these approaches to virtual or remote platforms, while still facilitating knowledge sharing, skills building, and improvement in overall quality of care at the district level.

7.3. EVALUATION QUESTION 3

What are the most significant accomplishments, best practices, and lessons learned from the ONSE Activity?

3a: How were these best practices systematically scaled up?
3b: What strategies, approaches, or methodologies did the Activity use to ensure sustainability?
3c: How were scale-up activities monitored and measured, and what level of sustainability was achieved?
3d: What were the challenges faced and how were they addressed/ overcome?

To better understand ONSE's accomplishments, the evaluation team conducted a brief review of the Malawi health sector in the years prior to the Activity. According to the 2010 Demographic and Health Survey, infant and child mortality rates decreased from 76 per 1,000 in 2004 to 66 per 1,000 in 2010 and from 133 per 1,000 to 112 per 1,000, respectively. The MMR decreased from 984 per 100,000 in 2004 to 675 per 100,000 in 2010. Despite those gains, a number of factors negatively impacted the health of Malawians. These included the availability and quality of health services, access to health services, and environmental and behavioral issues. The HSSP (2011–2016) was designed to address these factors to improve the health status of the people of Malawi. An EHP was agreed upon, covering diseases and conditions affecting the majority of the population and especially the poor. The EHP was updated in the HSSP II (2017–2022), categorizing services into priority classes using relevant criteria, expanding coverage for high-priority services to all Malawians, and ensuring disadvantaged groups would not be left behind. This was necessary because, the HSSP noted, "… the EHP has consistently been financially unobtainable and unsustainable."

Finding 3.1: SMART capacity building and HSS interventions emerged as the most significant accomplishments off the ONSE Activity. HSS interventions were considered among the best practices.

Of the 27 accomplishments noted by key informants, three received two or more citations (see Table 10). Of the 22 best practices noted, key informants cited five multiple times (see Table 11). In both cases, the highlighted accomplishments and best practices were drawn from a longer list of responses that focused primarily on either capacity building conducted by ONSE or its efforts to strengthen the health system.[14] This is confirmed by ONSE's monitoring data, which indicated that the Activity met or exceeded nearly all the targets for SMART capacity building, HSS, and addressing contextual factors (see Annex 6).

Table 10: Top Three Most Significant Accomplishments of ONSE, per KIIs

Intervention	KII Respondents
Improved WASH at the facility level	10
Improving competencies of health workers	6
Integrated support supervision	6

Table 11: Top Five Best Practices that Emerged from ONSE, per KIIs

Intervention	KII Respondents
DHIS2, data collection, and reporting	5
Intersectoral collaboration	4
Supportive supervision	4
Community engagement	3
Joint planning	3

Highlights from ONSE's monitoring data include the following:

- Of the target of 102 facilities, 141 (153 percent) were provided with improved infrastructure.
- ONSE supported 10,057 integrated family health outreach clinics to provide critical preventive and curative services.
- ONSE established and revitalized CHAGs and community champions to enhance communities' role in supporting community-led approaches with the involvement of village health committees. The LOA target for community champions was 100; the LOA achievement was 127.
- More than 3.8 million youth used youth-friendly health services—253 percent of the target of approximately 1.5 million.

Finding 3.2: While key informants noted many lessons learned, only one stood out.

> *"The project has mentored many MOH personnel in multi-tasked areas such as planning, budgeting, report writing, supervisory skills, etc. ONSE improved infrastructure in targeted health facilities such as pit latrines, placenta pits, drilling of boreholes, etc."* —Key informant

Through its analysis of the KII transcripts, the evaluation team derived 32 lessons learned, as cited by participants. However, more than two respondents cited only one of those lessons (ISS and mentorship leads to improvement in skills in all service areas)—noted by seven respondents. Nearly all the other lessons learned received only one reference. Examples included:

[14] The World Health Organization describes the six building block components of HSS as 1) leadership and governance; 2) service delivery; 3) health system financing; 4) health workforce; 5) medical products, vaccines, and technologies; and 6) health information systems. https://extranet.who.int/nhptool/BuildingBlock.aspx

- A large project requires massive preparation before it starts full implementation.
- Communities need to be supervised regularly to achieve maximum results of the health interventions they conduct.
- Effective empowerment involves bringing community and health facilities together to find solutions to challenges.
- The more people use data, the more the data improves.
- It is important to provide allowances on time to keep morale high.
- Program managers and coordinators need to be engaged to avoid implementation gaps.

Finding 3.3: In accomplishing its results, ONSE experienced several unintended consequences.

Unintended consequences differ from expected outcomes. They can be either positive or negative.[15] ONSE's commitment to strengthening gender parity and engaging women as leaders at the community level may have affected community power structures. ONSE used CHAGs as an avenue to promote women's leadership within communities, give women and girls voices, and provide a platform for women to join district health facility management teams. This may have contributed to changes in gender norms in Malawi. Implications for the future are not clear.

ONSE envisioned the mobile money system[16] as the main vehicle for per diem and transportation disbursements, daily subsistence allowances, and other payments at the district and community levels. Delayed payment of lunch allowances was a major issue that health service assistants and CHAGs mentioned several times in community-level FGDs. Participants who shared their experiences described the negative impacts of late payments on their morale. Although the system was thought to be innovative, it did not work as expected. Delayed payments (for as long as two months), created discontent, affected participants' motivation, and may have affected service delivery (for example, data collectors observed data entry staff sitting at their desks instead of entering data).

Finding 3.4: In collaboration with other relevant stakeholders, ONSE relied primarily on the rollout of information systems to monitor the progress of interventions and ensure that services were scaled up and used and that any challenges to scale-up were mitigated.

ONSE conducted baseline (2016–2017) and endline assessments (March 2022) to measure changes in the availability of health services offered by facilities in Activity districts. The baseline assessment included a census of every facility in the ONSE districts, and the endline assessment included a sampled subset of the facilities. The assessments found a substantial increase from baseline to endline in public facilities offering child health, FP, and maternal and newborn services (for example, facilities offering FP services increased from 82 percent at baseline to 100 percent at endline). Key informants reported that ONSE expanded services through routine collaboration with other stakeholders—particularly USAID IPs such as Health Communication for Life, Breakthrough Action and the Global Health Supply Chain–Procurement and Supply Management Activity. ONSE also collaborated with other partners, such as Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ), Last Mile Health, and UNICEF to address specific issues. This collaboration involved routine sharing of data and other information; joint district-level planning via informal and formal mechanisms (working groups) to avoid or limit duplication of efforts and a comprehensive and cohesive approach; joint participatory site visits, when possible (e.g.,

[15] Merton, R. (1936) "The Unanticipated Consequences of Purposive Social Action." *American Sociological Review 1 (6): 894. https://doi.org/10.2307/2084615.*

[16] The mobile money system was ONSE's preferred payment method for district activities because it is traceable, user-friendly, quick, secure, and transparent, with robust built-in controls and checks.

before and after COVID-19 lockdowns); discussions of emerging best practices, innovations, and lessons learned; and the cultivation of shared community champions to benefit all activities.

Finding 3.5: While ONSE incorporated measures to ensure the greater sustainability of interventions, these did not always align precisely with what key informants believed were the top factors for either ensuring sustainability or those that might pose risks to long-term adoption of practices.

One definition of sustainability in public health is the capacity to maintain program services at a level that will provide ongoing prevention and treatment for a health problem after the termination of major financial, managerial, and technical assistance from an external donor.[17] Some ONSE approaches may contribute to the continued use of interventions after the LOA. These included:

- Use of District Health Management Team Physical Asset Management units to provide technical support and Activity oversight.
- Reinforcing MOH technical and managerial capacity to ensure a meaningful transition as the ONSE Activity ended.
- Transitioning to the use of digital health tools for better data collection, feedback, and planning.
- Intensive skills transfer in integrated supervision, data collection, patient care, and other areas.
- Empowering communities through community champions and community action groups to identify challenges in their catchment areas and find sustainable solutions to local issues.
- The development of infrastructure such as maternity facilities, incinerators, and boreholes.
- Support to a sustainability task force (however this support was initiated too late to provide any notable benefit).

> *"Probably a few of the initiatives will be maintained, but obviously not all of them … I remember some of the districts already started supporting some of the initiatives … possibly they are going to be sustained, but most of them that have been costly, I think it will be doubtful [those will be sustained] if support is not coming forth."* —Key informant

The general perception among key informants was that capacity building of MOH personnel will contribute to sustainability because they will continue to use their new skills in Malawi. However, as seen in Table 12, perhaps some additional practices should receive greater emphasis to ensure sustainability. Additionally, as presented in Table 13, ONSE may have needed to survey its stakeholders at the start of implementation to ensure that the greatest perceived challenges to sustainability were further mitigated (although some of those challenges were outside of ONSE's manageable interest).

Table 12: Top Five Practices for Ensuring Activity Sustainability, per KIIs

Practice	KII Respondents
Ownership and empowerment of community	10
Community engagement	8
Mentorship of health workers	7
Economic empowerment of CHAGS	6
Training of officials at the health facility level to collect and input DHIS2 data	4

[17] Claquin, P. (1998). Sustainability of EPI: Utopia or Sine Qua Non Condition of Child Survival. Arlington, Virginia: Resources for Child Health Activity.

Table 13: Five Greatest Challenges for Ensuring Sustainability, per KIIs

Challenge	KII Respondents
No smooth or well-planned exit	9
No follow-on funding by GOM	8
Need for allowances	6
Lack of medical supplies	5
Cultural barriers	5

Finding 3.6: ONSE relied on routine Activity performance indicators to measure and monitor the scale-up of activities. However, no defined set of indicators was identified to track quantifiable progress on sustainability efforts.

Although sustainability was a clear goal in the Activity design, clear and distinct indicators demonstrating progress (or lack of progress) on sustainability were not always available. Instead, ONSE primarily used existing measurement systems (HMIS, DHIS2, and LMIS) to collect routine data to measure health indicators and monitor their progress. Through these indicators, ONSE monitored the progress of its work to determine whether the Activity was meeting its targets in areas such as HSS, access to EHP, quality of health services, and others. Including Activity-specific indicators in its AMEP would have been an informative addition to the Activity's monitoring and, in conjunction with contextual indicators, could have reflected a better sense of the sustainability of interventions and actions that were needed to mitigate any manageable challenges during the life of the Activity.

Finding 3.7: Key informants cited numerous challenges to ONSE's implementation, but there was no clear consensus on which were the most significant. In all likelihood, ONSE could have fully or partially mitigated some of the challenges, but others were outside of its manageable interests.

Challenges cited by key informants that ONSE could have fully or partially mitigated are listed in Table 14.

Table 14: Challenges that ONSE Could Have Mitigated

Challenge	Addressed? (Y/N/Partially)	How?
Sub-optimal collaborative efforts by ONSE at the Activity's outset	Yes/partially	• Repeated engagement with relevant stakeholders • Change of approach to soliciting ideas (within the bounds of its agreement)
Overpromising support/interventions prior to implementation	No	• N/A
Delayed allowance payments	Yes/partially	• Adoption of an electronic or mobile payment approach, although it did not work as expected • Limiting participants to those with phones (which may have had unintended inequity consequences)
Discontent with allowance provided	Yes/partially	• Onsite trainings, although these may have actually decreased participation
Stockouts of medicines and commodities at facilities	Yes/partially	• Transportation provided to supply commodities to health facilities facing stockouts when possible

Challenge	Addressed? (Y/N/Partially)	How?
Lack of MOH/GOM active participation	Yes/partially	• Repeated engagement, including, as possible, providing leadership roles in discussions (although some GOM officials expected direct financial benefits from participation)
Decreasing interest by community participants (CHAGs and youth) because of a lack of or limited incentives	No	• N/A
Lack of contextual understanding	Yes/partially	• Improved throughout the life of the Activity, although COVID-19 limited site visits for an extended period
Abrupt ending of some interventions (for reasons of funding or otherwise)	Yes/partially	• Improved communications with stakeholders, particularly at the district level
Attrition of health workers	Yes	• Repeated trainings, as well as follow-up mentoring
Transition of project activities (and sustainability)	Yes/partially	• Addressed in Finding 3.5

Challenges cited by key informants that were essentially outside ONSE's manageable interest included:

- Staff shortages at facilities;
- Lack of roads to access hard-to-reach areas;
- Limited resources; implementation limited to 16 districts;
- People seeking services outside the normal health facility catchment;
- Ongoing issues with utilities, primarily electricity;
- Scarcity of medicines and commodities;
- Lack of GOM procurement capacity; and
- Cultural barriers (e.g., early marriage and age of sexual debut).

7.4. EVALUATION QUESTION 4

What were the contextual factors, such as socioeconomic factors, gender, demographic factors, environmental characteristics, baseline health conditions, health services characteristics, and so forth that affected implementation and outcomes of the ONSE Activity?

4a: What key findings emerged?
4b: What were the challenges faced and how were they overcome?
4c: What more can be done in future activities of similar nature?

Finding 4.1: There was no single significant contextual factor cited by key informants as facilitating the implementation of ONSE.

Although ONSE addressed contextual and other enabling environment factors through its interventions (see Table 14), key informants did not mention what the most important factors were. Key informants did not mention any response more than three times. Some factors noted (of the 13 options) were:

- The flexibility and responsiveness of ONSE's approach and activities;
- CHAGs linkages between communities and health facilities;
- An established and coordinated MOH framework;

- The overall enabling policy environment;
- Having experienced coordinators within districts;
- Health workers with a positive attitude toward learning and using new knowledge; and
- The use of existing partnerships with the government.

Table 15: Contextual Factors Addressed by the ONSE Activity

Indicator	*Baseline*	*LOA target*	*Endline result*	*% LOA Target achieved*	*LOA Change from Baseline*
Number of USG-supported activities designed to promote or strengthen the civic participation of women	0	26	67	258%	0 -> 67 activities strengthening civic participation of women
Number of women's groups, girls' groups, and youth groups supported to facilitate their role as change agents in their communities	0	243	821	338%	0->821 female and youth organizations facilitated
Number of people reached by a USG-funded intervention providing GBV services	N/A	344	510	148%	**Baseline not available**
Number of policy dialogues and advocacy with public, private, and community organizations to address gender bias in access to and quality of services	0	11	8	73%	+8 policy/advocacy dialogues held
Number of civil society organizations receiving USG assistance engaged in advocacy interventions	0	137	252	184%	0 -> 252 organizations
Number of youth (10-24 years) utilizing youth-friendly health services in facilities supported with USG funds	105,000	1,505,000	3,805,512	253%	+3,700,512 youth (3,524% increase)
Percent of non-public health facilities (including CHAM, NGO, and private-for profit institutions) supported by USG to provide priority health services	46%	70%	77%	110%	67% increase

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90-99%)* *Achieved 100% or better*

Finding 4.2: Key informants cited several contextual factors as limiting ONSE's ability to implement interventions, and which the Activity addressed through its responsiveness to changing needs, initiating

cost-cutting measures, or greater involvement by community counterparts. However, not all limiting factors could be addressed.

As a result of these limiting factors, ONSE had to pivot on some interventions to ensure, for example, service continuity during the COVID-19 pandemic and the supportive supervision and mentoring that were foundational to its assistance. The Activity had to reprioritize interventions with a focus on district support, especially activities that facilitated service delivery such as FP and integrated family health outreach clinics; reduce central-level activities; and postpone resource-intensive activities such as facility renovation and WASH. In recognizing that further community engagement was needed, per key informants, ONSE increased its outreach efforts in at the local level with relevant stakeholders, especially to reduce cultural barriers to accessing the COVID-19 vaccine when it became available. Finally, the Activity initiated several cost-cutting measures such as reducing central level travel, and office rentals, and other line items when possible. However, several contextual factors were outside ONSE's manageable interests such as the level of funding (both Activity-specific and for the health sector in general), general macroeconomic conditions, and lack of facility access during the rainy season.

Table 16: Top Five Contextual Factors that Constrained ONSE, per KIIs

Factors	KII Respondents
Slow logistics	16
Shortage of funds	13
Exclusion of local structures	7
COVID-19 pandemic	6
Drug stockouts	6

Finding 4.3: Future activities can support the systematic use of data at the facility and community levels in each district to address some of the limiting factors.

> *"ONSE also aimed at complementing the DHIS2 effort in terms of the programs that they were supporting … There were improvements in terms of consistency of the reports that from the community level and district level for use at central level."* —Key informant

Malawi is moving steadily toward unifying and strengthening HIS, including DHIS2. The ONSE project correctly relied on and built capacity around existing data systems rather than creating a parallel data system for its AMEP and routine performance monitoring. Ensuring that these unified systems capture not only intervention-specific indicators and corresponding data, but also contextual factors should help to mitigate some of the issues which may impede implementation. Further, the continued strengthening of data-drive decision-making using a unified information system should provide continued progress in the areas which ONSE address as part of its Activity.

8. CONCLUSIONS

ONSE supported the GOM to provide essential health care services across 16 districts in several priority health areas covering a population estimated at 11 million to 12 million. To achieve its results, the Activity focused on four main objectives:

1. Increasing access to priority health services;
2. Improving the quality of priority health services;
3. Strengthening the performance of health systems; and
4. Increasing demand for priority health services.

Implemented from November 2016 to June 2022, ONSE was considered one of USAID/Malawi's flagship health activities and therefore merited an endline performance evaluation. The evaluation sought to assess the extent to which the Activity achieved its objectives regarding the quality of and access to care, provide insights into factors that facilitated and limited increased service utilization at each level of service delivery, and document progress toward building GOM capacity to deliver quality health services. Using the four primary questions below, and several sub-questions, the evaluation used a mixed methods approach to collect data for analysis. This resulted in the 17 findings discussed in Section 7, from which the following conclusions are derived.

Evaluation Question 1: To what extent did the Activity's interventions achieve their intended results?

For the most part, ONSE achieved its intended results as demonstrated by the monitoring data analyzed. Despite some shortcomings in certain categories (e.g., HSS and service quality), the Activity met or exceeded most targets. ONSE achieved LOA targets for 82 percent of its core indicators and at least 90 percent of LOA targets for 35 of 51 core performance indicators. While some key informants noted discord within the Activity because of differences in support packages that districts received, this did not significantly affect ONSE's ability to implement interventions, as demonstrated by the end results. Likewise, the onset of the COVID-19 pandemic did not appear to substantially reduce provision of services or achievement of results, pointing to ONSE's ability to adapt interventions to the changed circumstances. While some targets may have been affected due to the redirection of funding for COVID-19 and other unforeseen events, it appears to have navigated most of those challenges successfully. Finally, because of ONSE's focus on engagement with multiple stakeholders, abundant information provided by key informant feedback is part of this evaluation. This feedback points to future directions that USAID/Malawi might consider if it decides to continue with efforts similar to ONSE.

Evaluation Question 2: To what extent did ONSE improve access to priority high impact EHP interventions in the target health facilities and community service delivery points?

Examining only monitoring indicators focused on EHP, it can be concluded that ONSE substantially improved access to EHP services. Even though only three of the seven indicators listed in Table 7 met or exceeded their targets, three of the four remaining indicators did not underperform significantly: All were in the 90 percent to 95 percent range (the remaining indicator was at 81 percent of its target). Per key informant feedback, interventions that appeared to have the greatest effect on improving EHP services provision were aimed at HSS. Notably, these included improvements in supportive supervision, planning, and coordination, as well as efforts to strengthen the HIS and use of data for decision-making. Other interventions of note were ONSE's renovation of facilities, including provision of some

equipment, and strengthening of the supply ordering system. By utilizing the SMART capacity building approach, ONSE enhanced the health sector's overall systemic capacity at various geographic levels and improved the performance of individuals, teams, and structures working in and with Malawi's health system. Per key informant feedback, this increased a sense of programmatic ownership among Activity participants. For future activities, USAID/Malawi should consider and examine whether these EHP improvements were significantly better in ONSE districts than non-ONSE districts, as the evaluation's limited data analysis around this issue was inconclusive.

Evaluation Question 3: What are the most significant accomplishments, best practices, and lessons learned from the ONSE Activity?

Similar to the conclusion for Evaluation Question 2, stakeholders indicated that ONSE's HSS interventions were its most significant accomplishment, along with emerging best practices. They also identified the SMART capacity building approach as a notable achievement of the Activity. Given this recurring theme for these two areas, it can reasonably be concluded that future approaches to improving the health of Malawians (whether funded externally or domestically) should seriously consider incorporating a comprehensive design and hands-on methods for improving health services. Of particular note was the main lesson learned from ONSE: ISS and mentorship lead to improved skills in all service areas. Similarly, future approaches should address the unintended negative consequences of payment methods and incorporate better understanding of local gender dynamics.

While ONSE tracked the progress and scale-up of its interventions, primarily through the rollout of information systems and use of data, and utilized measures to better ensure sustainability, these efforts could have been improved. For example, ONSE could have been more proactive in ensuring scale-up in ways other than solely monitoring—for example, through focused and collaborative advocacy efforts with GOM officials. Likewise, the Activity could have better mitigated sustainability challenges by devoting measures to this issue and by seeking information at the start from a broad range of stakeholders regarding current and future challenges to sustainability. Finally, while ONSE, like any other activity, faced numerous implementation challenges both within and outside its manageable interests, it addressed most manageable challenges only partially through mitigation measures. Whether this was due to the Activity's management or other factors is unknown.

Evaluation Question 4: What were the contextual factors such as socioeconomic factors, gender, demographic factors, environmental characteristics, baseline health conditions, health services characteristics, and so forth that affected implementation and outcomes of the ONSE Activity?

Although ONSE addressed and measured a number of contextual factors related to implementation, key informants could not cite any one conclusive factor that aided in its success. However, several elements of a generally enabling environment (e.g., policies, coordination frameworks and mechanisms, enthusiastic and experienced personnel, and others.) point to the need to ensure that such elements are in place to ensure successful implementation. Respondents were more specific and cited more contextual factors that impeded implementation, although most of those were somewhat or wholly outside of ONSE's manageable interests (e.g., supply chain issues, lack of funding) or unforeseen events (e.g., the COVID-19 pandemic). Thus, while it is commendable that ONSE achieved a substantial portion of its intended results despite these challenges, opportunities for improvement (and, consequently, recommendations for future activities and interventions) remain.

9. RECOMMENDATIONS

Because this performance evaluation was conducted after the ONSE Activity ended, the recommendations listed below are directed at any future activities, whether funded domestically or by development partners. They are based on the findings discussed in this report and are divided into those that should be considered high priority and others for consideration. Finally, because external funding should be used to support Malawi's HSSP, in general the recommendations are aimed at all interested stakeholders. However, the recommendations indicate which stakeholders might be the primary leads.

9.1. HIGH PRIORITY

1. Regardless of the health issue to be addressed, an integrated HSS approach should be adopted. Within the six components of HSS, the following building blocks should be prioritized;

    - Health workforce development, particularly supportive supervision and mentoring;
    - Support to HIS, including the routine use of data for decision-making; and
    - Ensuring medical products, vaccines, and other technologies are available by strengthening the procurement and supply chain management systems.

    Lead stakeholders: USAID and the MOH equally.

2. Continue to use the SMART capacity building approach (as shown in Figure 11 and noted throughout the report). As reflected in the findings, participating stakeholders appreciated this approach, which should increase the sustainability of interventions (e.g., through enhanced skills and trainings).

    Lead stakeholders: USAID and its IPs primarily; potentially the MOH.

3. Balance demand for quality services with supply by ensuring that any participating health facilities are fit for purpose. To do so, conduct initial harmonized health facility assessments[18] to learn whether basic services (e.g., sanitation, infection prevention and control, electricity, clean water sources, waste disposal, etc.) are in place prior to the implementation of interventions and allow resources to be directed to resolving any infrastructure-related issues.

    Lead stakeholders: USAID and development partners primarily; potentially the MOH.

4. Continue to engage with communities, particularly around issues of mutual accountability for the quality of health services while offering members non-financial incentives for participating. The use of community scorecards has been shown to increase health service responsiveness and quality in numerous countries[19] and provides communities a tool to advocate for their health needs. However, as has also been shown, while they appreciate the improved services, community members often need other incentives. These can be purpose-driven (e.g., fostering a sense of shared goals), status-related (e.g., conferring prestige and recognition), and socially based (e.g., developing forums and events that are enjoyable and strengthen relationships).

    Lead stakeholders: USAID and MOH equally.

5. Define "sustainability" before implementing interventions and build it into any future activities. This involves including sustainability-related indicators in project documents and developing a sustainability, transition, and exit strategy that should be disseminated to and discussed with all counterparts (e.g., government officials, participating facilities, community members/clients of

[18] https://www.who.int/data/data-collection-tools/harmonized-health-facility-assessment/introduction#:~:text=The%20Harmonized%20Health%20Facility%20Assessment,at%20required%20standards%20of%20quality.
[19] CDC/ATSDR Committee on Community Engagement. (2011). Principles of Community Engagement, Second Edition.

facilities, and development partners) within the first year of implementation. This would allow for necessary joint planning to occur early and would define responsibilities for ensuring the short-, medium-, and long-term sustainability of activities.

Lead stakeholders: USAID and development partners primarily; potentially the MOH.

9.2. FOR CONSIDERATION

6. Build contingency plans into planning and programming documentation to allow for pivots, if needed, to respond to unforeseen events. While this evaluation found that the COVID-19 pandemic did not have a decisive impact on ONSE's ability to reach its goals, this was not the case for other activities in other countries. Nor was the COVID-19 pandemic the only type of unforeseen event that an activity might encounter. Thus, it is imperative that contingency and mitigation planning occur during the design stage. Further, development partners such as USAID should consider the types of agreements (e.g., grants, cooperative, agreements, contracts) that would best allow an activity to respond quickly to changing circumstances.

   Lead stakeholders: USAID; potentially the MOH.

7. Differentiate among partners' areas of manageable interest and lines of accountability. While, for example, ONSE's AMEP included indicators for contextual factors, many issues that the Activity encountered were only partially within (and, in some cases wholly outside) its manageable interest and ability to respond. A similar future activity could include a governing body comprising not only the donor organization and the IP, but also government counterparts, local participants, and community members. The terms of reference of such a group might include overseeing implementation, identifying bottlenecks, and, when possible, leveraging its members' positions to address and/or remove any impediments to implementation.

   Lead stakeholders: USAID and MOH equally.

8. Communicate early and widely, and explain the reasoning behind any differences in support to be provided. Whether funding is provided domestically or from a development partner, there are almost always gaps in support. Some geographic areas will be prioritized over others. Thus, the core stakeholders (the donor, the IP, technical working groups, etc.) must communicate to all participants the criteria for selecting participating districts and facilities and explain why levels of support may differ. While communication may not mitigate all issues, it allows participants opportunities to provide additional feedback and better understand the analysis that underlies the decision-making process.

   Lead stakeholders: USAID and MOH equally.

9. If resources are available, conduct an impact evaluation for any future activity, including any possible spillover effects. Impact evaluations can require years of planning and can be costly and labor-intensive. However, they can provide invaluable insights into the true extent of an activity's reach and effects. This endline evaluation offers some insights into ONSE's performance and its strengths and challenges, and attempts some cursory comparative analysis. However, the only robust method to ensure full understanding of the Activity's effects would have been the establishment of a counterfactual. While Malawi is geographically small, and spillover is possible of (e.g., interventions having effects beyond geographic boundaries), well-designed counterfactuals can incorporate these effects by, for example, including temporal elements and/or spatial analysis using geographic information systems.

   Lead stakeholders: USAID and development partners primarily; potentially the MOH.

ANNEX 1: SCOPE OF WORK

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

Global Health Evaluation and Learning Support Activity (GH EvaLS)
Contract No. GS-10F-154BA

STATEMENT OF WORK (SOW)
Date of Submission: _____
Last update: 02/03/2022

I. SOW SPECIFIC INFORMATION

A. TITLE:

1. ORGANIZED NETWORK OF SERVICES FOR EVERYONE'S HEALTH END LINE PERFORMANCE EVALUATION

B. FUNDER/REQUESTER/CLIENT

☐ USAID/Washington
Office/Division: _____ / _____

■ USAID Country or Regional Mission
Mission/Division: Malawi / HPN

C. FUNDING ACCOUNT SOURCE(S): (Click on box(es) to indicate source of payment for this assignment)

☐ HIV	☐ PIOET	■ FP/RH
☐ TB	☐ Other public health threats	☐ WSSH
☐ Malaria	■ MCH	■ Nutrition
		☐ Other (specify):

D. BUDGET CEILING: $600000 (Note: GH EvaLS will provide a cost estimate for this assignment based on this SOW.)

E. PERFORMANCE PERIOD

Expected start date (on or about): March 2022
Anticipated end date (on or about): September 2022

F. LOCATION(S) OF ASSIGNMENT

Please indicate where work will be performed: Malawi

II. TYPE OF ASSIGNMENT

A. EVALUATION:

1. Performance Evaluation ■

Please check timing of data collection:

□ Mid-term ■ Endline □ Other (specify): _____

Performance evaluations encompass a broad range of evaluation methods. They often incorporate before-and-after comparisons, but generally lack a rigorously defined counterfactual. Performance evaluations can address descriptive, normative, and/or cause-and-effect questions. As performance evaluations do not contain a rigorously defined counterfactual, they should not answer questions about the amount of change attributable to an intervention, where other factors are likely to have influenced the variable in question.

Please select the type of performance evaluation:

Outcome Evaluation: ■
Outcome evaluations are among USAID "final" evaluations, and address questions that focus on whether planned results and targets were achieved, as well as whether activities had unintended consequences. While many evaluations in this cluster are single point in time studies, some are more formal "pre-post" evaluations that fund both a baseline and endline round of data collection, but only for the activity's intended beneficiaries. This performance evaluation subtype does not include a comparison group, which is one of the characteristics that differentiates it from an USAID impact evaluation.

Mixed-Method Evaluation □
A mixed-method evaluation is one that uses two or more techniques or methods to collect the data needed to answer one or more evaluation questions. Some of the different data collection methods that might be combined in an evaluation include structured observations, key informant interviews, pre- and post-test surveys, and reviews of government statistics. This could involve the collection and use of both quantitative and qualitative data to analyze and identify findings and to develop conclusions in response to the evaluation questions.
the program are typically agreed upon before implementation.

III. ASSIGNMENT BACKGROUND

A. PROJECT/PROGRAM BEING EVALUATED/ANALYZED

Project/Activity Title:	Organized Network of Services for Everyone's (ONSE) Health
Award/Contract Number:	AID-612-C-17-00001
Award/Contract Dates:	November 15, 2016–June 30, 2022
Project/Activity Funding:	$107 million approximately
Implementing Partner(s):	Management Sciences for Health (MSH) Sub Awardees: Banja La Mtsogolo (BLM); Dimagi
Project/Activity AOR/COR:	Reuben Ligowe
Project/Activity Start Date:	November 15, 2016
Project/Activity End Date:	June 30, 2022

B. BACKGROUND OF PROJECT/PROGRAM/INTERVENTION AND CONTEXT

Background of project intervention

The overall purpose of the Organized Network of Services for Everyone's Health (ONSE) Health Activity is to reduce maternal, newborn, and child morbidity and mortality. It is expected that this will be achieved by working with the Ministry of Health (MoH) and other stakeholders to deliver on four intermediate results (IRs): (1) improving access to priority health services; (2) improving quality of priority health services; (3) strengthening performance of health systems; and (4) increasing demand for priority health services. In addition, ONSE is providing targeted support to the national response to COVID-19, particularly at the district level according to the needs of each district in which ONSE is present.

To increase the availability and accessibility of quality priority health services, ONSE seeks to shift the paradigm of the most effective way to build skills and improve performance among staff. This involves moving from traditional training to 'smart' approaches that focus on competency and performance, as well as the systemic capacity needed to support and maintain performance. Understanding that the system is the foundation upon which an effective continuum of care rests, ONSE focuses on providing technical assistance, rather than direct service delivery, requiring close coordination and alignment with government actors at each level of the system, as well as other partners. This assistance includes support to district health and health facility

managers for planning, leadership and management, governance, and advocacy. ONSE's approach to communities demarcates an important change from purely mobilizing demand and changing behaviors, to actively engaging with communities to enable them to identify and tackle their own health issues and hold the system accountable for maintaining the availability and quality of services.

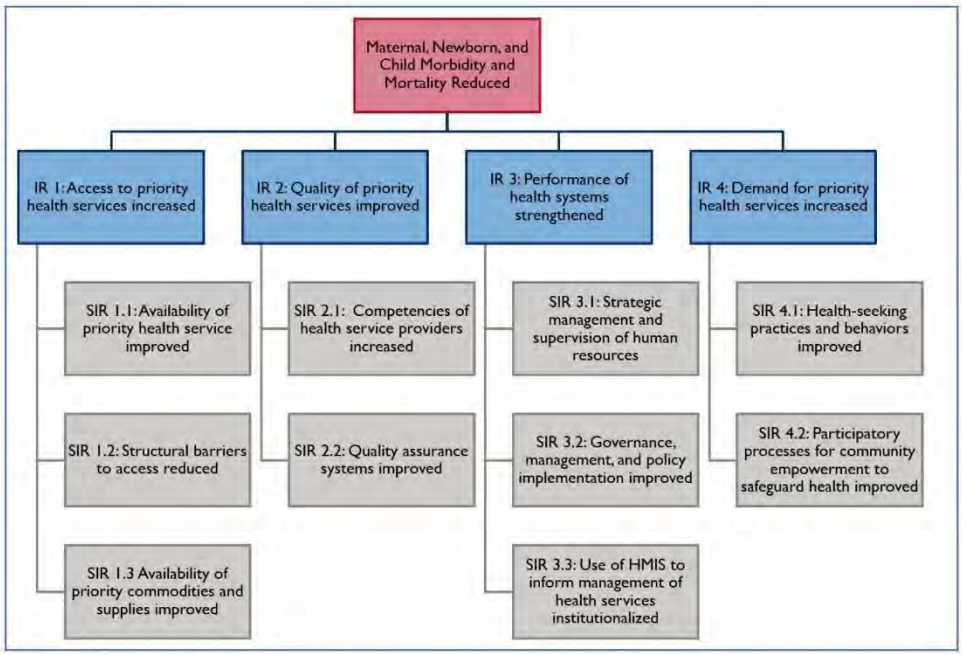
In all this, ONSE's expectation is to support the Government of Malawi's (GOM) efforts to reduce maternal, newborn, and child mortality through; (1) Improved access to maternal, newborn, and child health (MNCH), including nutrition, family planning/reproductive health (FP/RH), malaria, and water, sanitation, and hygiene (WASH) services; (2) Improved quality of these four priority health services; (3) Strengthened district health systems in support of MNCH, FP/RH, malaria, and WASH; and (4) Increased community demand for these priority services. To accomplish this, interventions will be implemented in health systems strengthening (HSS) and four core technical areas—FP/RH, MNCH, malaria, and WASH.

C. THEORY OF CHANGE OF TARGET PROJECT/PROGRAM/ INTERVENTION

Please paste the Theory of Change below.

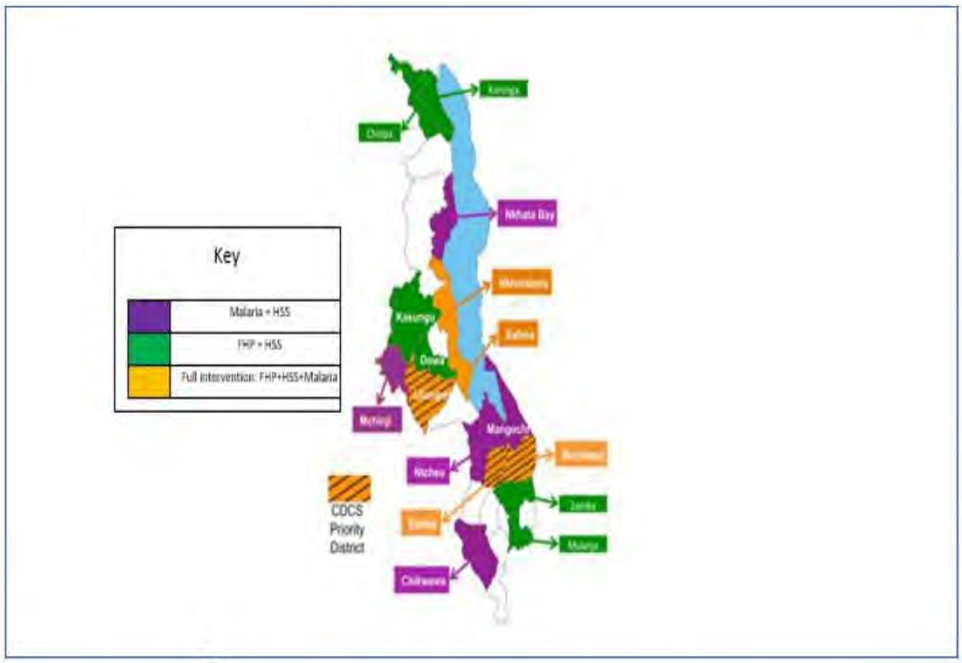
D. STRATEGIC OR RESULTS FRAMEWORK FOR THE PROJECT/PROGRAM/ INTERVENTION

Please also paste the framework below.



E. GEOGRAPHIC COVERAGE

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



B.

ONSE activities are undertaken in sixteen (16) districts of the country namely:
Balaka, Chikwawa, Chitipa, Dowa, Karonga, Kasungu, Lilongwe, Machinga, Mangochi, Mchinji, Mulanje, Nkhata Bay, Nkhotakota, Ntcheu, Salima, and Zomba. As indicated in the map above, the color codes show the level of implementation. It should be noted however that Malaria interventions are not included in the cost extension period beginning 1st July 2021 to June 2022.

IV. PURPOSE, AUDIENCE, & APPLICATION

A. PURPOSE

Why is this assignment being conducted (purpose of assignment)? Provide the specific reason for this assignment linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

USAID/Malawi's office of Health Population and Nutrition (OHPN) wishes to conduct an end line performance evaluation of its flagship project Organized Network of Services for Everyone's health (ONSE). It is a USAID flagship, five-year activity designed to effect change through improved access to and quality of a broad range of services, i.e., maternal, neonatal, and child health including nutrition (MNCH), family planning/reproductive health (FP/RH), malaria, and water, sanitation and hygiene (WASH) services; strengthened district health systems in support of these services; and increased community demand for these priority services. The Activity is USAID's primary mechanism for engagement in Malawi's health sector at the district, facility, and community levels; contributing to achieving USAID Ending Preventable Child and Maternal Death (EPCMD) goals; and increasing the modern contraceptive rate. Components of ONSE include Health Systems Strengthening; Health Service Delivery; Quality Improvement, and Community mobilization. The current project was scheduled to end in September 2021 after being granted a no cost extension and was further accorded a cost extension to end in June 2022.

The aim of the end line performance evaluation is to assess the extent to which project objectives have been achieved regarding quality of and access to care; provide in-depth insights into the factors facilitating and limiting increased service utilization at each level of service delivery, and document progress made towards building the Government of Malawi (GOM) capacity to deliver quality health services.

The findings of this evaluation will inform MOH, USAID, and other development partners in the design and prioritization of future investments in strengthening Malawi's Health System, as well as feed into adaptation of existing activities where possible. Furthermore, this evaluation will be used by USAID to learn whether and to what extent this project met the stated objectives of improved access to and quality of a broad range of services, i.e., maternal, neonatal, and child health including nutrition (MNCH), family planning/reproductive health (FP/RH), malaria, and water, sanitation and hygiene (WASH) services; strengthened district health systems in support of these services; and increased community demand for these priority services. It will also provide in depth insights into the facilitating and limiting factors of increased service utilization at each level of service delivery. In addition, USAID will use this evaluation to identify activities that warrant continued investment and any additional recommendations to strengthen future program implementation.

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 evaluation results and report will be used by USAID, Ministry of Health and other stakeholders to inform future project design.

C. APPLICATIONS AND USE

How will the findings be used? What future decisions will be made based on these findings?

The findings will be used by USAID and other implementing partners implementing similar projects and will also inform the design of future programs for USAID. In addition, the evaluation outputs must provide recommendations to USAID/Malawi and the Ministry of health to inform future implementation of integrated health service delivery-focused programming.

V. ASSIGNMENT QUESTIONS & MATRIX

The evaluation will consider three broad themes - Effectiveness, Access, and Quality, and the contractor must review, analyze, and evaluate the activity with these three themes in mind. USAID has undertaken to align the questions to the following requirements:
a) aligned with the assignment purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.) that must be incorporated into the assignment questions. USAID Evaluation Policy recommends 1 to 5 evaluation questions.

	[*Evaluation/Assessment/ Study*] **Question**	**Suggested methods for answering this question** *What data sources and data collection and analysis methods will be used to produce the evidence for answering this question?*	**Sampling Frame** *Who is the best source for this information? What is the sampling criteria?*
1	To what extent did the project's interventions achieve their intended results? What changes, if any, were made to activities and how did those changes positively or negatively affect the project's achievement of its results?	In-depth Interview/ Key Informant Interview; project documents	USAID Personnel, Government officials, program managers of partner organizations, program staff, etc
2	To what extent did ONSE improve access to priority high impact Essential Health Package (EHP) interventions in the target health facilities and community service delivery points? Of the capacity strengthening approaches employed by ONSE, which have most enabled the MoH to address systems-	In-depth Interview, / Key informant Interview, Observation, Service Statistics/ data	USAID personnel, Program Managers, Program Staff, Health Care Providers,

	level issues at central and district levels?		
3	a. What are the most significant accomplishments, best practices, and lessons learned from the ONSE activity? b. How were these best practices systematically scaled up? c. What strategies, approaches, or methodologies did the project use to ensure sustainability? d. How were scale-up activities monitored and measured, and what level of sustainability was achieved? e. What were the challenges faced and how were they addressed/overcome?	In-depth Interview, / Key informant Interview, Observation, Service Statistics/ data; project documents/reports	USAID personnel, Program Managers, Program Staff, Health Care Providers,
4	What were the contextual factors such as socioeconomic factors, gender, demographic factors, environmental characteristics, baseline health conditions, health services characteristics, and so forth that affected implementation and outcomes of the ONSE project? a. What key findings emerged? b. What were the challenges faced and how were they overcome?	In-depth Interview/ Key Informant Interview, Focus Group Discussion	USAID Personnel, Program Staff, Health Care providers, Other IPs, other donors, etc

	c. What more can be done in future projects of similar nature?		

VI. DATA COLLECTION METHODOLOGY

-

C. Instructions: Describe the recommended methods for this assignment. Selected methods should be aligned with the assignment questions and fit within the time and resources allotted for the assignment. Also, include the sample or sampling frame in the description of each method selected.

Note Related to Methods
A critical part of the methodology will be to assess the situation during the COVID-19 pandemic. It is anticipated that for the assignment, especially where borders are closed and access is restricted, highly qualified national/regional evaluators and experts will be contracted. Additionally, virtual approaches to data collection will be used, including virtual stakeholder meetings, key informant interviews, and focus groups, where possible. See also USAID Guide to Remote Monitoring in COVID-19.

Please choose from the following options:

■ Document and Data Review

Please provide a 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 assignment. Documents and data to be reviewed include: Project reports, service statistics, Contract Agreement, PMP, Quarterly Reports, Workplans, and Management Reviews, etc. A link to the stated documents will be provided once populated.

■ Secondary Analysis of Existing Data

This is a re-analysis of existing data, beyond a review of data reports. Please list the data source and recommended analyses.

Data Source (existing dataset)	Description of Data	Recommended Analysis
Project indicator performance data	Data cutting across the period of performance for the project to show progress and results that were tracked	
Fixed fee Indicator Verification reports	As a contractual agreement, certain	

	indicators were aligned to fees upon achievement of at least 90% of the targets. verification exercises were conducted to confirm, and reports are available for secondary analysis.	

Key Informant Interviews

Please list categories of key informants and purpose of inquiry.

USAID personnel, Project staff (Home Office and in-country staff), Country level Ministry of Health, collaborators/partners, donors, healthcare providers and managers, and beneficiaries. They will be interviewed for the role they played in supporting the interventions and for those that benefited will be interviewed to establish how they felt and provide any challenges they experienced while accessing the services.
There will be 48 KIIs within 8 districts.

Focus Group Discussions

Please list categories of groups and purpose of inquiry.

Health care providers for the role they played in supporting the interventions; clients/beneficiaries for purposes of establishing how they viewed the services they received and what they found to be valuable, and any challenges experienced while accessing the services.
There will be 4 focus group interviews.

Group Interviews

Please list categories of groups and purpose of inquiry.

Key informants may be interviewed in small groups of similar respondents, if all participants feel free to express their own opinions. The purpose is as above.
There will be 4 small group interviews.

D. Note on Human Subject Protection

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

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

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

VII. ASSIGNMENT ANALYSIS PLAN

Instructions: Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data is to be triangulated (if appropriate). For example, conduct a thematic analysis of qualitative interview data, or complete a descriptive analysis of quantitative survey data. The box below has been filled out to provide you with an example that you should edit, as necessary.

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

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

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

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

The Evaluation Report will describe all analytic methods and statistical tests employed during the evaluation.

VIII. ACTIVITIES

Instructions: List the expected key activities, such as Team Planning Meeting (TPM), briefings, verification workshop with IPs and stakeholders, etc. Activities and deliverables may overlap. Please give as much detail as possible.

1. **Desk Review** – Several documents are available for review for this assignment. These include ONSE proposal, annual work plans, M&E plans, quarterly progress reports, and routine reports of project performance indicator data, as well as survey data reports (i.e., DHS and MICS) where necessary. This desk review will provide background information for the Assignment Team and will also be used as data input and evidence for the assignment.

2. **Assignment Launch/In-brief with USAID** – A call/meeting with the USAID, GH EvaLS project staff, and the Assignment Team (Team) to initiate the assignment and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH EvaLS will introduce the Team and review the initial schedule and other management issues.

3. **Team Planning Meeting** – A three to four-day team planning meeting (TPM) will be held at the initiation of the assignment and before the data collection begins. During the TPM, the Team will:
   - Review and clarify any questions on the assignment SOW
   - Clarify team composition from EvaLS and USAID, and members' roles and responsibilities
   - Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion
   - Review and finalize the assignment questions
   - Review and finalize the assignment timeline
   - Develop a draft of the data collection methods, instruments, and guidelines
   - Review and clarify any logistical and administrative procedures for the assignment
   - Develop a preliminary data collection plan
   - Draft the assignment work plan
   - Develop a preliminary draft outline of the team's report
   - Assign drafting/writing responsibilities for the final report or final presentation

4. **Work Plan and Methodology** submitted to USAID and followed by a review meeting. Work Plan will include:
   - Assignment timeline
   - Assignment questions
   - Proposed methodology
   - Data collection strategy, sampling frame, and selection criteria

- Data analysis plan describing procedures that will be used to analyze qualitative and quantitative data
- Data and resource requirements
- Data collection instruments

5. **In-brief with the target Project/Program** to review the assignment plans and timeline, and for the project to give an overview of the project to the Assignment Team.

6. **USAID and Stakeholder Briefings** – The Team Lead (TL) will brief the USAID POC **biweekly** to discuss progress. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.

   A **final debrief** between the Assignment Team and USAID will be held at the end of the assignment and before the preparation of the final report, to present **preliminary findings to USAID**. During this meeting, a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The Assignment Team will incorporate comments received from USAID during the debrief in the assignment report. (*Note: preliminary findings are not final and as more data sources are developed and analyzed these findings may change.*)

7. **Fieldwork: Site Visits and Data Collection** – The Assignment Team will conduct site visits for data collection. Selection of sites to be visited will be finalized during the TPM in consultation with USAID. The Assignment Team will outline and schedule key meetings and site visits prior to departing to the field. During the time of COVID-19, all protocols as recommended by the presidential task force on COVID -19 will be adhered to and followed. If there are restrictions to field visits and travel and where borders are closed, highly qualified national/regional evaluators and experts will be contracted. In addition, alternative means of data collection will be used, such as virtual stakeholder meetings, key informant interviews, and focus groups, where possible. See also USAID Guide to Remote Monitoring in COVID-19.

8. **Assignment Report** – The Assignment Team, under the leadership of the TL, will develop a report with findings and recommendations. Report writing and submission will include the following steps:
   - TL will submit a draft final report to GH EvaLS for review and formatting
   - GH EvaLS will submit the draft report to USAID/Malawi
   - USAID will review the draft report in a timely manner, and send their comments and edits back to GH EvaLS
   - 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.)*

- 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
- GH EvaLS will review and reformat the final report, as needed, and resubmit to USAID for approval.
- Once the final report is approved, GH EvaLS will reformat it for 508 compliance and post it to the DEC.

The evaluation/analytic report **excludes** any **procurement-sensitive** and other sensitive but unclassified (**SBU**) information. This information will be submitted in a memo to USAID separate from the report.

9. **Submission of Datasets to the Development Data Library** – Per USAID's Open Data policy (ADS 579, USAID Development Data), GH EvaLS may submit all quantitative data to USAID and the Development Data Library (DDL), at www.usaid.gov/data, in a machine-readable format (CSV or XML). The datasets created as part of this evaluation/analytic activity will be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data will be public once posted on USAID's DDL.

   Qualitative data that do not contain identifying information should also be submitted to GH EvaLS.

10. **Submission of Final Evaluation Report to the Development Experience Clearinghouse** – Per USAID policy (ADS 201.3.5.18), GH EvaLS will submit the final evaluation/analytic report to the Development Experience Clearinghouse (DEC) within three months of final approval by USAID.

IX. TASKS, DELIVERABLES, AND TIMELINES

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

Tasks/Deliverables	**Timelines & Deadlines** (estimated)
Assignment Launch /In-brief with USAID	Week 1 of assignment launch
Desk Review	Weeks 1-3
Team Planning Meeting/In-depth discussion with USAID on workplan and methodology (inception report)	Weeks 2-3
Inception report review briefing	Week 3
Inception review submission (includes assignment questions, methods, timeline, data analysis plan, and data collection instruments)	Week 4
Incorporating USAID's feedback on Inception Report, the targeted stakeholder groups/individuals who will participate in the evaluation, and data collection tools (Inception Report finalization).	Week 5
In-brief with target project	Week 6
Preparation for data collection/logistics	Weeks 6-7
Fieldwork: site visits and data collection	Week 8-12
Routine USAID briefings	Biweekly
Debrief with USAID with PowerPoint presentation on progress of the assignment and preliminary findings	Week 14
IP & stakeholders findings review workshop with PowerPoint presentation	Week 15
Report writing (Draft Report)	Weeks 16-17
Draft report review by GH EvaLS	Weeks 18-19
USAID review of the Draft Report	Weeks 20-21

GH EvaLS & Assignment Team incorporate USAID comments	Weeks 22-23
Final report submission to USAID	Week 24

Estimated USAID review time
Average number of business days USAID will need to review the report? **5** business days

X. TEAM COMPOSITION, SKILLS, LEVEL OF EFFORT (LOE), AND LOGISTICAL NEEDS

A. TEAM COMPOSITION AND SKILLS:

Instructions: Please list technical areas of expertise required for this assignment:

- List desired qualifications for the team as a whole
- List the key staff needed for this analytic assignment and their roles

Please also consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leads for evaluations/assessments must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an Evaluation/Analytics Specialist, who should have evaluation/analytic methodological expertise needed for this assignment. Similarly, other analytic activities should have a specialist with methodological expertise.
- All team members will be required to provide signed Non-Disclosure and Conflict of Interest statements attesting that they will keep all information confidential and have no conflict of interest (COI) or describing the conflict of interest, if applicable, for further consideration.

Required Positions:

1. Team Lead (Key Staff 1):

Roles & Responsibilities: The TL should have significant experience conducting and leading project evaluations and/or assessments. The TL will be responsible for: providing team leadership; managing the team's activities; monitoring team LOE; ensuring that all deliverables are met in a timely manner; serving as a liaison between USAID and the team; and leading briefings and presentations.

Qualifications:

- Minimum of 10 years of experience in public health, including experience in implementation of health activities in developing countries
- Demonstrated experience leading health sector project/program evaluation/assessment activities, utilizing both quantitative and qualitative methods
- Excellent skills in planning, facilitation, and consensus building

- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Excellent skills in project management
- Excellent organizational skills and ability to keep to a timeline
- Good writing skills, with extensive report writing experience
- Experience working in the East, South and Central African region, and experience in *Malawi* will be an added advantage.
- Familiarity with USAID
- Familiarity with USAID policies and practices including:
    - Evaluation policy
    - Results frameworks
    - Performance monitoring plans

2. Evaluation Specialist (Key Staff 2)

Roles & Responsibilities: This consultant serves as a member of the assignment team, providing quality assurance on analytic issues, including methods, development of data collection instruments, protocols for data collection, data management, and data analysis. S/He will oversee the training of all engaged in data collection, ensuring the highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the assignment, from planning, data collection, and data analysis to report writing.

Qualifications:
- At least 10 years of experience in USAID M&E procedures and implementation
- At least 5 years managing M&E, including evaluations and/or assessments
- Experience in design and implementation of evaluations and/or assessments
- Strong knowledge, skills, and experience in qualitative and quantitative analytic tools
- Experience implementing and coordinating others to implement surveys, key informant interviews, focus groups, observations, and other evaluation and assessment methods that assure reliability and validity of the data.
- Experience in data management
- Able to analyze quantitative data, which will be primarily descriptive statistics and cross- tabulations
- Able to analyze qualitative data
- Experience using analytic software
- Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
- Experience conducting secondary analysis of existing quantitative datasets
- Able to review, interpret, and reanalyze, as needed, existing data pertinent to the evaluation
- Strong data interpretation and presentation skills
- Proficient in written and spoken English

- Good writing skills, including experience writing evaluation and/or assessment reports
- Familiarity with USAID health programs/projects, particularly in the area of [insert topic(s) related to specific assignment]
- Familiarity with USAID and/or PEPFAR M&E policies and practices including:
    - Evaluation policies
    - Results frameworks
    - Performance monitoring plans

3. Public Health Specialist (Key Staff 3)

Roles & Responsibilities: Serve as a member of the Team, providing expertise in Public Health. S/He will participate in planning and briefing meetings, development of data collection instruments, data collection, data analysis, development of presentations, and writing of the final report.

Qualifications:

- At least 8 years' experience with Public Health projects; USAID project implementation experience preferred
- Expertise in supply and demand for MNCH, FP/RH services at the community and clinical level
- Familiarity with public health integration is desirable
- Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
- Proficient in English and other local languages (Chichewa, Tumbuka)
- Good writing skills, including experience writing evaluation and/or assessment reports
- Experience in conducting USAID evaluations of health programs/activities

4. Local Staff Titles with Roles & Responsibilities (include number of individuals needed):

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

Local Evaluators will assist the Team with data collection, analysis, and data interpretation. They will have basic familiarity with health topics, as well as experience conducting surveys, interviews, and focus group discussions, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed. The Local Evaluators will have a good command of English and Chichewa and Tumbuka. They will report to the TL.

5. USAID Participation

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

☐ Full member of the Team (including planning, data collection, analysis, and report development) – If yes, specify who: _____

■ Some Involvement anticipated – If yes, specify who: __Veronica Chirwa and Reuben Ligowe_____

☐ No

B. STAFFING LEVEL OF EFFORT (LOE) MATRIX AND ANTICIPATED TRAVEL

2. LOE Chart

Instructions: The LOE Matrix below will help you estimate the LOE needed to implement this assignment. If you are unsure, GH EvaLS can assist you to complete this table. Please note:

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

The following is an **illustrative** LOE Chart. Please edit to meet the requirements of this assignment. The level of effort is in **days** for each Team member.

Tasks/Deliverables		Assignment Team				
		eam Lead ey Staff 1)	Evaluation Specialist Key Staff 2)	Public Health Specialist ey Staff 3)	Local aluator (s) Staff 4 and 5)	Local Evaluation Logistics Coordinator (Staff 6)
Number of persons		1	1	1	2	1
1	Launch/In-brief with USAID	2	2	2	2	2
2	Desk review	5	5	5	5	.5
3	In-brief with Mission	1	1	1	1	1
4	Team Planning Meeting (TPM)	3	3	3	3	1
5	Inception report briefing with USAID	1	1	1	1	1

6	Inception report production/ submission (includes assignment questions, methods, timeline, data analysis plan, and data collection instruments)	4	4	4	4	1
7	In-brief with target Project/Program	2	2	2	2	1
8	Data collection workshop (protocol orientation/training for all data collectors) – as necessary	5	5	3	5	2
9	Preparation/logistics for site visits and data collection	1	1	1	1	4
10	Fieldwork: site visits and data collection (including travel to sites)	10	10	5	31	25
11	Data analysis	10	10	7	10	
12	Debrief with USAID with PowerPoint presentation on progress of the assignment and preliminary findings (including preparatory work)	2	2	2	2	

13	**IP & stakeholders review workshop with PowerPoint presentation (including preparatory work)**	1	1	1	1	
14	**Draft report for submission**	10	10	10	10	
15	**Revise report per USAID comments for submission**	5	5	2	2	
	Total LOE per person	62	62	49	80	38.5
	Total LOE	62	62	49	160	38.5

3. Anticipated Travel

Please list international and local travel anticipated and by what team members.

no international travel

C. LOGISTICS

1. Work week

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 ☐ No

A 6-day workweek permitted ☐ Yes ☐ No

6-day workweek approved for travel to/from work locations ☐ Yes ☐ No

2. Visa Requirements

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

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

Name of Country	Type of Visa		
	c Tourist	c Business	c No preference
	c Tourist	c Business	c No preference
	c Tourist	c Business	c No preference
	c Tourist	c Business	c No preference

3. Clearances & Other Requirements

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)

□ High Threat Security Overseas Seminar (HTSOS) (*required in most countries with ECC*)

□ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)

□ GH EvaLS workspace
Specify who will require workspace at GH EvaLS: _____
_____

□ Travel, other than posting (specify): _____

□ Other (specify): _____

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

Note on Workspace and Clearances

Most Teams arrange their own workspace, 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 the country more than 45 consecutive days, the consultant may be required to complete the one-week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in Blackstone, 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.

•

X. GH EvaLS ROLES AND RESPONSIBILITIES

GH EvaLS will coordinate and manage the team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for assignment
- Recruit and hire the 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, evaluation/analytical 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, submitting to the DEC, and posting on GH EvaLS website. If the report is internal, then copy editing/formatting for internal distribution.

XI. USAID ROLES AND RESPONSIBILITIES

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

Sample:

GH EvaLS COR Responsibilities

The role of the COR team is to ensure the overall quality of EvaLS deliverables. They will track the progress of the assignment and may review early drafts of the reports as they become available. They are available to USAID clients if they have any questions or concerns during the implementation of the assignment.

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will help 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 CVs 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.

XII. FINAL REPORT

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

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

- The report must not exceed 25-30 pages (excluding executive summary, table of contents, acronym list, and annexes).
- The structure of the report should follow the Evaluation Report template, including branding found here or here.
- Draft reports must be provided electronically, in English, to GH EvaLS who will then submit it to USAID.

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

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

- Evaluation/Assessment reports should be readily understood and should identify key points clearly, distinctly, and succinctly.
- The Executive Summary of an evaluation/assessment report should present a concise and accurate statement of the most critical elements of the report.
- Evaluation/Assessment reports should adequately address all assignment questions included in the SOW, or the assignment questions subsequently revised and documented in consultation and agreement with USAID.
- Assignment methodology should be explained in detail and sources of information properly identified.
- Limitations of the assignment should be adequately disclosed in the report, with particular attention to the limitations associated with the methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Findings and conclusions should be specific, concise, and supported by strong quantitative or qualitative evidence.
- If assignment findings assess person-level outcomes or impact, they should also be separately assessed for both males and females.
- If recommendations are included, they should be supported by a specific set of findings and should be action-oriented, practical, and specific.

Reporting Guidelines: The draft report should be a comprehensive, analytical, evidence-based evaluation/assessment report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding

procedures. ***The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.***

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

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

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

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

All data instruments, data sets (if appropriate), presentations, meeting notes, and report for this evaluation/analysis will be submitted electronically to the GH EvaLS Project Manager. All datasets developed as part of this assignment will be submitted to GH EvaLS in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data.

Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses, and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

XIII. USAID CONTACTS

	Primary Contact	Alternate Contact 1	Alternate Contact 2
Name:	Veronica Chirwa	Reuben Ligowe	
Title:	Branch Chief M and E (FH/HSS Team)	MNH Specialist	
USAID Office/Mission	HPN/Malawi	HPN/Malawi	
Email:	vchirwa@usaid.gov	rligowe@usaid.gov	
Telephone:			
Cell Phone:	+265888062551	+265884518574	

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

	Technical Support Contact 1	Technical Support Contact 2
Name:	Bamikale Feyisetan	Belay Mengistu
Title:	Senior Evaluation and Sustainability Advisor	Division Chief – FH/HSS
USAID Office/Mission	GH/PRH	HPN/Malawi
Email:	bfeyisetan@usaid.gov	bmengistu@usaid.gov
Telephone:	202-916-4740	
Cell Phone:	571-215-6894	+265887375400

XIV. OTHER REFERENCE MATERIALS

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

XV. ADJUSTMENTS MADE IN CARRYING OUT THIS SOW AFTER APPROVAL OF THE SOW

E.

F. To be completed after assignment implementation by GH EvaLS.

ANNEX 2: DATA COLLECTION TOOLS

District Health Management and Administration levels: District Health Management Team, Advisor Committee, Environment, Officer, District FP Coordinators, District Youth Officer, District Environment Officer, District Water Officer

Conduct Informed Consent and obtain essential information from the Cover Page.

I. Background

1. Can you discuss with me a little bit about your work here at this office?

Probe:

- What is your position title?
- Responsibilities
- Length of employment at the current position while engaging with ONSE

2. How have you interacted with the project?

II. District Health Service Delivery

1. What would you say have been the most remarkable changes/improvements thanks to the project that you've seen during your time here as a_____.

Probe: **Integration** of services for fewer resources?
Who accesses these different services?

	Covid	FP	Nutrition	ANC	Malaria	GBV	IPTp[1]
Women							
Men							
youth							

- Who gets to benefit from these improvements? Youths, women, men, etc. (probe for: In what ways did the youth (boys/girls, men and women)
- Find out if they know if different groups go to different facilities for different needs or are there other factors involved in seeking care elsewhere?
- What are the barriers to the different groups wanting to seek services?

2. Can you discuss how the District has been more *responsive* to the population health needs (MNBH, CH, FP, **IPTp,** youth, malaria, nutrition, etc. consistent with MOH goals?

[1] Only ask in two districts, to confirm with MSH.

3. How does the district interact and work with the Community Advisory Group to mobilize communities to take responsibility of their community's health?

4. Can you discuss how the DHMT/DIPs ensure services to populations in hard-to-reach areas?
5. How can the District Health Management Team ensure a continuity of quality health services once the project ends?
6. What challenges were experienced with the implementation of the project and how were these addressed?

7. What are the lessons and best practices that you can share to inform future projects? Probe for:
    - Which best practices were put in practice?
    - How did you go about it?

III. Information System – DHIS2

1. Can you talk about how the facility's information system for collecting, using, and reporting data? How does it work?

    Probe:
    - How to ensure quality data?
    - How does the facility use the data to improve service(s)?
    - Can you give me an example where this has happened?
2. From your perspective, how else can the DHIS2 be improved?

Probe:
- What have been the challenges in operationalizing the system at the district level?
- Are there any other issues? Data completeness, timeliness? Data utilization? What can be done?
- What have been the lessons learned that can be used in the future?

3. Ensuring that medicines and other essential clinical materials are stocked and delivered when needed are ongoing efforts, how does the District Team plan and manage the supply chain?

Probe:
- What system(s) are used? Open Logistics Management Information System
- What have been some challenges and how were they resolved?

4. What recommendations do have for strengthening the supply chain in Malawi?

IV. Capacity-Building and Supervision

1. Can you discuss some of the training or other supportive activities you benefited from over the project life? (e.g., mentoring, supportive supervision, simulation-based training, etc.'
2. In what ways have you applied/used learned knowledge and skills in your job? Probe: If they haven't applied X, Y, Z skills, If they haven't applied, why not?
3. Which of these capacity strengthening approaches would you say enabled the MoH to address systems level issues at district and central levels?
4. What have been the challenges you've encountered in doing your work (related to ONSE project activities)? How did you resolve the issue(s)?

V. District Governance & Planning

1. Perhaps you can help me better understand the role and responsibilities of the DHMT (different offices at district) and how district work is planned and managed.

Probe:

- DIP reviews – What does that entail?
- Inter-sectoral coordination?
- Integrated Supportive Supervision?
- Other activities
-

2. Who or what agencies/organizations provide oversight and support to the DHMT in the last 5-6 years?
3. What kinds of support has your office received? From ONSE? From GoM or other agencies?
4. Can you talk about the coordination efforts amongst and between offices and agencies in developing and implementing DIPs?

Probe: Inter-sectoral; at different levels?

5. What has changed in terms of coordination efforts over the years?

Probe:

- Why? (What factors contributed to changes)
- Areas of strength and challenges in coordination?
- How can coordination/leveraging capacities be strengthened in the future?

6. How does the DHMT supervise/manage the work of district health facilities?

Probe:

- What have been some strategies or systems in place to ensure quality work, troubleshoot, etc.?

7. What are some lessons learned from ONSE implementation? What is needed for sustaining positive results at the district level?
8. To what extent do you think the project's interventions achieve their intended results?

VI. Sustainability

1. What strategies, approaches or methodologies did the project use to ensure sustainability?
   District facility supporting community health advisory group?
   Community empowerment such as CCs?
   Partnerships across sectors?
   Management tools?
   Others?
2. What activities were scaled up? (How were they measured, monitored?, How sustainable have they been)

3. What components of the project will continue after the project ends? Why do you say that?

At this time, you can ask for clarifications from the previous responses.

Allow KI to comment or questions? Thank them!

District Health Facility levels: QI Support Team, Clinic Officers, OB/GYN Specialist, Nested Providers, MNH Mentors, Nurse Midwives, Nurse Midwife Technician, HSA Supervisors, Pharmacy Assistants

Conduct Informed Consent and obtain essential information from the Cover Page.

I. Background

1. Can you tell me a little about your work here at this facility?

Probe: (similar to other tools)

- Title
- Responsibilities
- Length of employment

2. How have you interacted with the project?

II. Health Service Delivery

1. What would you say have been the most remarkable changes/improvements thanks to the project you've seen during your time here as a_____.

2. Explain/describe how **Integration** of health services has been operationalized in the district?

- Who gets to benefit from these improvements? Youths, women, men, etc.?
- In what ways for the different groups, the youth (boys/girls, men and women)?
- Find out if they know if different groups go to different facilities for different needs or are there other factors involved in seeking care elsewhere?
- What are the barriers to the different groups wanting to seek services?

The Table is to help you organize your data and probe accordingly. It is not meant for you to shorten the answers. We want to know who receives what services from where as well as the barriers to getting those services.

Access

Type of care/service	Access by:	Facility XYZ	Challenges
FP			
COVID vaccine			
Malaria			
MNH			
Nutrition			
CH			
Youth			
GBV			
IPTp			

Probe: Why don't people want to get COVID vaccine?
What are issues for the youth in trying to access health service?

3. Are you familiar with the Community Health Action Group (CHAG)? How does the health facility interact/support community advisory group to mobilize communities for better health?

4. In your own view: *Does* the CHAG do what it is supposed to do?
    a. *Probe if they provide accountability and improvement to health service delivery?*
    b. *How did the CHAG help during COVID in terms of education the community and encouraging them to adopt healthy behaviors and get vaccinated?*
5. *Did the* CHAG meet the health needs for individuals as well as the communities of this area?

    What challenges did encounter working with the community advisory group?

6. Among the different service interventions that the project has introduced (MNBH, CH, FP, Youth, Malaria, Nutrition, WASH) in the facility, which do you think have been utilized *more***?**

Probe:
- What could be the reasons for such levels of utilization?
- Which are *less* utilized? And what could be the reasons?
- For less utilised services, what would encourage people to come to the facility for _____ service?

7. how would you describe the **quality** of services at this facility? (GBV, MNBH, CH, FP, Youth, Malaria, Nutrition, WASH)

    Probe:
    - Can you talk about the quality of service for each type as relevant for the facility?

    Make sure to obtain an explanation for **why** for each response.

8. What are other areas that have improved at this facility?

    Probe:
    - Renovations
    - What about equipment?
    - Commodities – medicines, contraceptives, vaccinations

- Ask about the challenges of renovations, equipment, commodities and How have you addressed the challenges

III. Information System – DHIS2

1. Can you talk about how the facility's DHIS2 for collecting, using, and reporting data work?

   Probe:
   - Data quality, (completeness, correctness consistency) and timeliness?
   - How does the facility use the data to improve service(s)?
   - Can you give me an example where this has happened?

2. What challenges do you experience with the use of Ipis DHIS2?
3. How do you propose the challenges be addressed to improve DHIS2 performance?

IV. Capacity-Building and Supervision

1. Can you discuss f the training or other supportive activities you benefited from over the project life? (e.g., mentoring, supportive supervision, simulation-based training, etc.)
2. In what ways have you applied/used learned knowledge and skills in your job? Probe: If they haven't applied X, Y, Z skills, What could be the reasons?
3. What have been the challenges you've encountered in doing your work (related to ONSE project activities)? How did address those challenges?

V. Responsiveness to District Population Health

1. How do you think the facility has been responsive to the district population's health needs in providing MNBH, CH, FP, youth, malaria, nutrition, etc.?
   Probe: How has the district health facility supported the community advisory group?
2. What are the lessons learned from ONSE implementation?
3. What have been the best practices in the response?
4. What is needed to sustain the best practices?

VI. Sustainability

1. What strategies, approaches or methodologies did the project use to ensure sustainability? (What exit strategies were put in place to ensure sustainability, partnerships were established?)
2. What activities were scaled up? (How were they measured, monitored? How sustainable have they been?)
3. What components of the project will continue after the project ends? Why do you say that?

At this time, you can ask for clarifications if needed. Allow KI to comment or questions? Thank them!

Health Providers & Volunteers, HSA, Community Based Distribution Agents, iCCM providers, Youth RH Assistants, Safe Motherhood Coordinators, Malaria Coordinators and Supervisors, Youth, Male and Women Champions, Community Health Volunteer

Conduct Informed Consent and obtain essential information from the Cover Page.

I. Background

1. Can you tell me a little bit about your work that concerns the ONSE project?

Probe:

- Title
- Roles and responsibilities
- Length of employment / service at this facility and health sector

2. What has been your role in carrying out ONSE project activities?

II. Work

1. What would you say have improved in health status /conditions in your community since you started working with ONSE?

Probe: Improved Access?

- Who accesses for what service(s)
- Service Quality over duration?
- Behavior change stories with women/men/youth?

2. What have been some challenges you encountered in carrying out your work?

Probe:

- How did you overcome those challenges?
- Who helped you resolve these challenges?

3. Can you talk about how you coordinate your activities with others in the community?

III. Community Outreach and Engagement

1. Can you describe how you mobilize and educate communities for healthy behaviors, e.g. **COVID** healthy practices including getting vaccinated, go to the health center for MNH, wash hands, etc. (**probe for health call centers, by phone**)

Participant	Mobilization and/or other activities	Frequency	Where District/village

Youth RH Assistants			
Youth Champion			
Women Champion			
Men Champion			
Safe motherhood coordinator			
iCCM Provider			
HSA			
CHV			
CBD Agents			
Malaria Coordinator			

2. How have your work//activities evolved over the ONSE project life?
   Probe: providing **multiple**/integrated services to communities?

3. How do you keep track of your activities?

Probe:

- Community Score Cards?
- Monthly report to coordinator or district level?

IV. Capacity-Building and Supervision

1. Can you discuss some of the training you benefited from over the project life?

Probe:

- How have they helped your work?

Trainings

Type of Training	Approximate Date	Useful/applied to job

2. In what ways have you used learned knowledge and skills in your job? Probe: If they haven't applied learned skills, what is the reason?
3. Can you discuss if/how the district health facility has supported your work in delivering community outreach?

4. Can you describe the different kinds of support you receive?

Probe:

- Monthly supervision visits?
- Mentoring?
- Village Health Committee support?
- Others?

5. Do you believe that communities have increased the demand for services and that there is more accountability of the local health facilities for the services they provide to communities? How so?
6. Are there any other lessons learned from your work you would like to share with me?
7. Do you have community health action groups (CHAGs)?
8. Would you explain how you work with the CHAGs?
9. What has been the impact of the CHAGs on health service delivery in your health facility?

At this time, you can ask for clarifications if needed. Allow KI to comment or questions? Thank them!

GH EvaLS Malawi ONSE End-line Performance Evaluation

Checklist for Conducting FGDs with Community Beneficiaries

I. Access to Information and Community Outreach

1. Can you tell us where you get health (FP/MNH/Malaria/WASH/nutrition/etc.) information? *Please list all the access points mention by the group.*

Type of Services	Where you get health information?	Why do you access through that channel?	Who do you *'trust most'* for the information
Family Planning			
MNH			
Malaria			
WASH			
Nutrition			
Others *(Please Specify)*			

Probe:

2. How often do you participate in community mobilization/gatherings (information) and/or other kinds of outreach (CBDs or iCCM)?
    - *Please inquire the frequency per specified period e.g. Per Month, Per Year etc.*

3. What have you learnt from these gatherings/outreach that changed your life (changed the way you live).
    - *Please list elements that have been learnt by members of the community.*

4. Have you shared your health (FP/malaria/WASH/nutrition/child health/TB etc.) knowledge with your family and friends? Why or why not?

II. Community Health Delivery

1. Can you discuss the kinds of community health services you've received over the last 5 years (Before-During and After the Covid-19 pandemic)?

- *Note: Please probe and align the respondent and associated responses to the following timelines:*

Pre-Covid 19	Before 2020	During Covid 19	2020-2021	Post-Covid 19	2022

Fill the group's responses in the Table below:

Type Community Outreach Service	When? Indicate the timeframe: (Write: **Before/During/After**)	Were the outreach services useful **(Y/N)**	How did they encourage you and the community to adopt healthier behaviors?

2. How would you feel about the delivery of the community health services?

   Probe for specific service(s) received. For example, COVID vaccine, FP, ANC, nutrition, etc. And Why?

3. Are you familiar with the Community Health Action Group (CHAG)?
   a. *Can you explain to me the role and responsibilities of the CHAG?*
4. In your own view: *Does* the CHAG do what it is supposed to do?
   a. *Probe if they provide accountability and improvement to health service delivery?*
5. *Did the* CHAG meet the health needs for individuals as well as the communities of this area?
6. *What challenges did you meet with the CHAG? How did you deal with them?*
7. *Will the community be able to continue activities implemented by CHAG? YES/NO, Explain reasons for your answer?*
8. *What are your suggestions to improve the CHAGs and activities they provided?*

III. Champion Community

1. Do you have a Champion Community in this area?
2. Are you familiar with the Champion Communities?
   a. Can you explain to me the role and responsibilities of CC?
3. In your own view: Do the Champion Communities do what they were supposed to do?
4. *Do the* CC meet your needs for individuals as well as the communities of this area?
5. What challenges did you meet with the CC? How did you deal with them?
6. In your own view, will the Champion Communities continue in the next several years? YES/NO, explain reasons for your answer?
7. What are your suggestions to sustain Champion Communities efforts?

IV. Facility-based Experience

1. Can you discuss your experience in accessing care as well as service in the last year? *(Probe their experience before-during and after the COVID-19 pandemic).*
2. How do you feel about the quality of care as well as services you received? Why?
3. What are the reasons why members of the community fails to seek care or/and service health facilities?
4. What should be done to encourage members of the community to access care or/and service from health facilities?
5. What can help to ease access barriers that limit youth/men/women seek care/services from health facilities?

V. Concluding

1. Is there anything else you would like to share with us about accessing care and services by community members from health facilities?
2. If necessary, ask for clarifications if needed.

	Interviewer's observations *(Participants views, Structures and behavior)* or interpretations:

End of Discussion

Thank You All for Taking Part in this Group Discussion!

ANNEX 3C: INTERVIEW GUIDES

Key Informant Interview Guides

GH EvaLS Endline Performance Evaluation for Organized Network of Services for Everyone's (ONSE) Health in Malawi

Central Level: USAID, ONSE Project incl. consortium partners, and other Development Actors

Conduct Informed Consent and obtain essential information from the Cover Page.

I. Background

1. What has been your engagement in the ONSE Project (and ways in which you have interacted with it)?

   Probe further for:
   - Job position/Title
   - Responsibilities
   - Length of employment in current position (to see how long been engaged with ONSE)

II. Technical Assistance

1. A. What types of support has GoM received from ONSE?
   B. What have been the technical assistance and other kinds of support ONSE provided to GoM over the project life? (Other Development Actors may not know this question, skip)
2. What have been some outcomes from the various supports over the years?

   Probe:
   - Access and improved quality of services (e.g., which types of services, at which levels, and beneficiaries?)
   - Provision of Essential Health Package?
   - Planning and management of services, resource allocation
   - Information system
   - Supply chain
   - Community participation

3. How has the project supported the GoM in strengthening its health system, including decentralization efforts?

Type ONSE Support	Project Year	Results from supports
1		
2		
3		

4		

III. Governance

1. How has the coordination (inter-sectoral) efforts between the central and district levels been operationalized? What have you observed as changes to the district health management team efforts to independently manage activities, provide services to the communities etc to meet local need and doing so in equity such as reaching the hard-to-reach populations?

2. What has changed in terms of coordination efforts over the project years?

   Probe: efforts PY1 through PY6
   - What have been some challenges in coordination efforts?
   - What was done to resolve these challenges?
   - Does the Central level provide guidance/supervision to district-level officials?
   - Probe How so?
   - For Improved Competency/Simulation Training/Mentoring/Coaching?
   - For Integrated Supportive Supervision system?

IV. Information Systems – DHIS2 and Supply Chain

1. Can you talk about how the country's information system for collecting, using, and reporting health data? How does it work? Has it improved over the project's life? (probe for both completeness and timeliness of reporting)

   Probe: How does the facility **use** the data to improve service(s)?
   - Can you give me an example where this has happened?
   - From your perspective, how else can the DHIS2 be improved?

   Probe: What are some challenges/needs/gaps?
   - Lessons learned that can be used in the future?

2. Ensuring that medicines and other essential clinical materials are stocked and delivered when needed are ongoing efforts, how does the district team plan and manage the supply chain?

   Probe:
   - What system(s) are used? Open Logistics Management Information System
   - What have been some challenges and how were they resolved?

3. Can we talk about the community health information system, how is it being used in the district?
4. Do you have any recommendations for strengthening the supply chain in Malawi?

Probe for whether they think the GoM will ensure adequate stocking, including transferring overstocked to stock out commodities to different places.

V. ONSE Achievements

1. Do you think the project has achieved one of its main objectives, that is i**ntegration** of services with fewer resources? Please explain in what ways integration worked or didn't work well.

2. What about health system strengthening? How would you described the health system capacities after ONSE interventions.

   Probe: What do you think have attributed to these achievements? Integrated Supportive Supervision?

3. What about community empowerment? Do you think these efforts will continue after the project life?

4. Can you talk about the challenges the project encountered over the project life?

5. How were these challenges resolved?

Probe:
Can you discuss/share 'local solutions'?
Who got involved, where, what level?

VI. Coordination/Leveraging Efforts (ONSE Sub-awardees)

1. Can you describe the management structure of ONSE during the project life?

Probe: How did the prime IP coordinate efforts with all partners on activities?

2. How would you describe the collaborations between ONSE IPs (consortium partners as well as other development agencies/organizations?) to increase project efficiency and effectiveness?

VII. Sustainability

1. Aside from mHealth, are there other project components that can be sustainable?

   Probe:
   - Like certain HSS aspects like mentoring, nested providers?
   - Others?

GH EvaLS Endline Performance Evaluation for Organized Network of Services for Everyone's (ONSE) Health in Malawi

Central Level: Officers from departments from MOHP, Ministry of Agriculture, Irrigation, and Water Development, Ministry of Youth and Gender, Zonal Officers of MOH
Conduct Informed Consent and obtain essential information from the Cover Page.

I. Background

1. What has been your engagement in the ONSE Project?
2. How have you interacted with the project?

Probe further for:

- Job position/Title
- Responsibilities
- Length of employment at current job and engagement history with ONSE

II. Technical Assistance

1. A. What types of support has GoM received from ONSE? (GoM; USAID)
   B. What have been the technical assistance and other kinds of support ONSE provided to GoM over the project life?
4. What have been some outcomes from the various supports over the years?

Probe:

- Access and improved quality of services (e.g., which types of services, at which levels, and beneficiaries?)
- Provision of Essential Health Package?
- Planning and management of services, resource allocation
- Information system
- Supply chain
- Community participation

2. How has the ONSE project supported the GoM in strengthening its health system, including decentralization efforts?

Type ONSE Support	Project Year	Results from supports
1		
2		
3		
4		

III. Governance

1. How has the coordination (inter-sectoral) efforts between the central and district levels been operationalized? What have you observed as changes to the district health management team efforts to independently manage activities, provide services to the

communities etc to meet local need and doing so in equity such as reaching the hard-to-reach populations?

2. What has changed in terms of coordination efforts over the project years?

Probe efforts PY1 through PY6:

- What have been some challenges in coordination efforts?

3. What was done to resolve these challenges?
4. Does the Central level provide guidance/supervision to district-level officials?

Probe how so?

- For Improved Competency/Simulation Training/Mentoring/Coaching?
- For Integrated Supportive Supervision system?

IV. Information Systems – DHIS2 and Supply Chain

1. Can you talk about how the country's information system for collecting, using, and reporting data? How does it work? Has it improved over the project's life? (probe for both completeness and timeliness of reporting)

Probe:

- How does the facility **use** the data to improve service(s)?
- Can you give me an example of where this has happened?
- From your perspective, how else can the DHIS2 be improved?
- What are some challenges/needs/gaps? What was done?
- Lessons learned that can be used in the future (local)?

2. Ensuring that medicines and other essential clinical materials are stocked and delivered when needed are ongoing efforts, how does the District Team plan and manage the supply chain?

Probe:

- What system(s) are used? Open Logistics Management Information System
- What have been some challenges and how were they resolved?

3. Can we talk about the community health information system, how is it being used in the district?
4. Do you have any recommendations for strengthening the supply chain in Malawi?

V. ONSE Achievements

1. Do you think the project has achieved one of its main objectives, that is i**ntegration** of services with fewer resources? Please explain in what ways integration worked or didn't work well.

2. What about health system strengthening? How would you described the health system capacities after ONSE interventions.

Probe: What do you think have attributed to these achievements? Integrated Supportive Supervision?

3. What about community empowerment? Do you think these efforts will continue after the project life?

4. Can you talk about the challenges the project encountered over the project life?

5. How were these challenges resolved?

Probe:
- Who got involved, where, what level?

VI. ONSE Coordination

1. How would you describe the collaborations between ONSE IPs (consortium partners as well as other development agencies/organizations?) to increase project efficiency and effectiveness?

VII. Sustainability

1. Aside from mHealth, are there other project components that can be sustainable?

Probe:
- Like certain HSS aspects like mentoring, nested providers?
- Others?

Key Informant Interview Guide

(FINAL additional interviews – district level)

INTERVIEW GUIDE

(Note to data collectors: Please feel free to probe for more in-depth information if the interviewee states something of interest or something which is unusual)

1. (Background question): What has been your engagement in the ONSE Project and what are the ways in which you have interacted with it?

2. (EQ2) What types of support has ONSE provided to you? What do you believe were the most beneficial activities / technical assistance that ONSE provided for your work?

3. (EQ1) During the life of the ONSE project, what changes, if any, were made to activities? Did those changes positively or negatively affect your interaction with the project and any goals you had wanted to achieve?

4. (EQ4) What were the main challenges the ONSE project faced and how were they overcome?

5. (EQ4) Are there any greater contextual factors (e.g., socioeconomic factors, political factors, environmental issues, etc.) that affected implementation and your interaction with the ONSE project? If so, how did these factors affect the results achieved?

6. (EQ3) What are the most significant accomplishments, best practices, and lessons learned from the ONSE Activity?

ANNEX 3: LIST OF DOCUMENTS REVIEWED

1. Activity Monitoring and Evaluation Plan: Organized Services for Everyone's Health (ONSE Health). March 2017.
2. ONSE Health Activity Malawi: Annual Activity Report- PY1. October 2017.
3. ONSE Health Activity Malawi: Annual Activity Report- PY2. October 2018.
4. ONSE Health Activity Malawi: Annual Activity Report- PY3. October 2019.
5. ONSE Health Activity Malawi: Annual Activity Report- PY4. October 2020.
6. ONSE Health Activity Malawi: Annual Activity Report- PY5. October 2021.
7. ONSE Quarterly reports, 2016-2022
8. Organized Network of Services for Everyone's Health (ONSE) Activity Malawi: Annual Workplan FY17. January 2017.
9. Organized Network of Services for Everyone's Health (ONSE) Activity Malawi: Annual Workplan Y2. September 2018.
10. Organized Network of Services for Everyone's Health (ONSE) Activity Malawi: Annual Workplan Y3. August 2019.
11. Organized Network of Services for Everyone's Health (ONSE) Activity Malawi: Annual Workplan Y4. August 2020.
12. Organized Network of Services for Everyone's Health (ONSE) Activity Malawi: Annual Workplan Y5. August 2021.
13. ONSE Health Activity: Health Facility Assessment- District Assessments. January 2018.
14. Together For Everyone's Health: ONSE Final Project Report- Malawi, 2016-2022. June 2022.
15. ONSE Health Activity Malawi: Endline Report. July 2022.
16. Request for Proposal (RFP) No: SOL-612-16-000001- Organized Network of Services for Everyone's (ONSE) Health. February 2016.
17. Government of the Republic of Malawi: Health Sector Strategic Plan II (2017-2022). April 2017.
18. A cluster randomized trial of delivery of intermittent preventive treatment of malaria in pregnancy at the community level in Malawi: IPTP in Malawi. 2020.
19. Management of Health Information in Malawi: Role of Technology. Advances in Science Technology and Engineering Systems Journal. January 2017.
20. Malawi Government: National Health Communication Strategy 2015-2020. 2020.
21. Draft Baseline Report: Malawi Organized Network of Services for Everyone's Health (ONSE) Impact. November 2017.
22. Government of the Republic of Malawi: Ministry of Health- National Digital Health Strategy 2020-2025. May 2020.
23. Government of the Republic of Malawi: Ministry of Health- Malawi National Health Information System Policy. September 2015.
24. Government of the Republic of Malawi: Ministry of Health- National Community Health Strategy 2017- 2022. July 2017.
25. ONSE Health Activity Malawi: WASH Strategy Document. June 2018.
26. Impact Evaluation of Malawi's Organized Network of Services for Everyone's (ONSE) Health Project: Baseline Report. July 2018.
27. The Republic of Malawi Ministry of Health: The Malawi COVID-19 Vaccine Deployment Plan. February 2021.

28. ONSE Health Activity: Addressing Malaria in Pregnancy in Malawi-Community-Based Delivery of IPTp: Study Brief. December 2021.
29. ONSE Health Activity: SMART CAPACITY BUILDING Brief.
30. ONSE Health Activity: ONSE Joint-Planning and Resource Allocation Process Brief.
31. Unpacking our Impact: The ONSE Health Activity Approach to Planning Presentation. June 2020.
32. Civil Society Organization Capacity Assessment. January 2017.
33. ONSE Partner Mapping 2017.
34. ONSE Health Activity: ONSE Highlights Brief.
35. ONSE Health Activity: Youth-Friendly Health Services (YFHS) Assessment.
36. Assessment of EMR Systems in Malawi: Draft Initial Landscape Assessment. Vital Wave. February 2019.
37. Organized Network of Services for Everyone's (ONSE) Health Activity, Malawi: Strategic Communications and Outreach Strategy. June 2017.
38. ONSE Health Activity: Community Mobilization and Engagement Brief.
39. ONSE Health Activity: Fixed Fee Comments.
40. ONSE Health Activity: Annual Survey Approach.

ANNEX 4: QUALITATIVE RESEARCH ACTIVITIES

Organization and Districts	Planned	Completed
USAID (Malawi Mission)	**4**	**2**
KIIs	4	2
ONSE (Central and District Level)	**4**	**5**
KIIs	4	5
Central Government (Central Level)	**4**	**4**
KIIs	4	4
Implementing Partners	**3**	**4**
KIIs	3	4
International Development Actors	**4**	**2**
KIIs	4	2
Lilongwe	**12**	**14**
KIIs		10
GIs		2
FGDs		2
Balaka	**12**	**12**
KIIs		7
GIs		2
FGDs		3
Machinga	**12**	**11**
KIIs		5
GIs		3
FGDs		3
Chikwawa	**12**	**14**
KIIs		10
GIs		2
FGDs		4
Karonga	**12**	**14**
KIIs		9
GIs		2
FGDs		1
Nkhata Bay		**2**
KIIs		2
Ntcheu		**1**
KIIs		1
Chitipa		**1**
KIIs		1
Kasungu		**1**
KIIs		1
Nkhotakota		**2**
KIIs		2
Total	**79**	**89**

ANNEX 5: LENGTH-OF-ACTIVITY DATA INDICATOR TARGETS AND RESULTS BY USAID IR AND SUB-IR

Evaluators conducted secondary review of quantitative data collected, analyzed and reported by the USAID Malawi ONSE Project to assess LOA performance. Data were sourced from the ONSE Project Final Report (Draft), as provided to more accurately and comprehensively analyze trends and changes in performance indicators over the full 5+ years of project implementation as well as to evaluate whether planned targets were met.

Below are tables of ONSE Key Performance Indicators for each ONSE IR and Sub-IR approved by USAID, their targets, their endline results, and the LOA quantitative change in final results from the baseline. Baseline data was not available for some indicators, as noted in the LOA Change from Baseline column, and quantitative change from baselines could not be determined for those indicators.

A "traffic light" shading is applied to % of LOA targets achieved, with Green indicating 100% or higher, Yellow – 90-99% target achievement, and Red – an 89% or lower target result (legends included at the bottom of each table). LOA Change from Baseline results cells shaded gray indicate a decrease in achievement from the related indicator target set for the LOA.

*Table 9: ONSE Target Results for **IR 1- Access to Priority Health Services Increased***

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
1-1. Couple Years Protection	675,000	4,590,000	3,828,930	83%	+3,153,930 CYP (467% increase)
1-2. Percent of health facilities providing priority health services					
Child Health	74%	92%	100%	109%	35% increase
Family Planning	82%	95%	100%	105%	22% increase
Maternal and Newborn Health	54%	80%	90%	113%	67% increase
Malaria	96%	99%	100%	101%	4.2% increase
KMC	63%	85%	67%	79%	6.4% increase

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90%-99%)* *Achieved 100% or better of target*

For this evaluation, an LOA Target Achieved score was considered for indicator results that met 90% or above of the approved target by the conclusion of project activities and funding and as presented in the Draft Final Report of the ONSE Project. LOA Change from Baseline results cells shaded in gray indicate a decrease in achievement from the related indicator target set.

Table 9a: ONSE Target Results for ***Sub-IR 1.1. Availability of priority health services in targeted districts improved***

Indicator	*Baseline*	*LOA target*	*Endline result*	*% LOA Target achieved*	*LOA Change from Baseline*
1.1-1. Percent of USG-supported facilities that provide BEmONC in the past three months	32%	65%	21%	0%	34% decrease
1.1-2. Number of newborns not breathing at birth who were resuscitated in USG supported program	3,500	34,500	49,821	144%	+46,321 newborns (1,324% increase)
1.1-3. Percent of non-public health facilities (including CHAM, NGO and private-for-profit institutions) supported by USG to provide priority health areas	46%	70%	77%	110%	67% increase
1.1-4. Number of people gaining access to basic drinking water services as a result of USG assistance	0	55,500	66,570	120%	0 -> 66,570 people with drinking water access
1.1-5. Number of people gaining access to a basic sanitation service in WASH targeted districts as a result of USG assistance	0	104,245	110,000	106%	0 -> 110,000 people with basic sanitation services
1.1-6. Number of institutional settings gaining access to a basic drinking water services as a result of USG assistance	0	78	85	109%	0 -> 85 settings with basic drinking water services
1.1-7. Number of basic sanitation facilities provided in institutional settings as a result of USG assistance	0	102	131	128%	0 -> 131 settings with basic sanitation facilities
1.1-8. Number of cases of child diarrhea treated in USG-assisted programs	230,000	1,593,895	1,478,000	93%	+124,800 cases (543% increase)

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
1.1-9. Number of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs	155,000	1,269,000	1,200,068	95%	+1,045,608 women (674% increase)
1.1-10. Number of calls received through CCPF	656	65,656	79,226	121%	+78,570 calls (12,000% increase)
1.1-11. Number of facilities with improved infrastructure as result of USG-assistance	0	92	141	153%	0 -> 141 facilities
1.1-12 Percent of newborns that received at least one dose of chlorhexidine to the cord on the first day of birth (ENAP indicator)	81%	100%	91%	53%	+10% of newborns (12.4% increase)
1.1-13. Number of newborn infants receiving antibiotic treatment for infection through USG-supported programs	0	22,282	41,044	184%	0 -> 41,044 infants
1.1-14. Number of children who received DPT3 (PENTA III) by 12 months of age in USG-assisted programs	0	1,070,600	1,155,504	108%	0 -> 1,155,504 children
1.1-15. Number of children 12-23 months who received measles-rubella second dose through USG-assisted programs	0	599,759	542,672	90%	0 -> 542,672 children
1.1-17. Number of children under five years of age suspected with pneumonia receiving antibiotics by trained facility or community health workers in USG-assisted programs	0	1,820,800	3,016,169	166%	0 -> 3.07 million <5 children receiving antibiotics for pneumonia

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90%-99%))* *Achieved 100% or better of target*

*Table 9b: ONSE Target Results for **Sub-IR 1.2. Barriers to accessing priority health services reduced***

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
1.2-1. Number of youth (10-24 years) utilizing youth-friendly health services in facilities supported with USG funds	105,000	1,505,000	3,805,512	253%	+3,700,512 youth (3,524% increase)
1.2-3. Number of children under five (0-59 months) reached by USG-supported nutrition programs	638,000	3,538,000	1,963,302	56%	+1,325,302 children (208% increase)
1.2-4. Number of children under two (0-23 months) reached with community-level nutrition interventions through USG-supported programs	220,000	*1,027,101*	*500,047*	49%	+280,047 children (127% increase)
1.2-5. Number of pregnant women reached with nutrition interventions through USG-supported programs	*242,000*	*1,916,800*	*1,557,978*	81%	+1,315,978 women (544% increase)
1.2-6a. Percent of health service delivery points offering community-based priority Child Health services	67%	90%	80%	57%	23% increase
1.2-6b. Percent of health service delivery points offering community-based Family Planning health services	65%	92%	59%	0%	6% decrease
1.2-7. Percent of USG-supported communities establishing an emergency transport system for pregnant women	40%	71%	70%	101%	75% increase
1.2-8. Number of USG-assisted community health workers (CHWs) providing Family Planning (FP) services	0	5,887	9,661	164%	0 -> 9,661 CHWs providing
1.2-9. Number of people receiving improved service quality from an existing basic drinking or safely managed water services as a result of USG assistance	0	55,500	66,570	121%	0 -> 66,570 people
1.2-10. Percent of communities (group villages) using Community Scorecard (CSC) methodology	30%	60%	57%	104%	90% increase

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90%-99%)* *Achieved 100% or better of target*

*Table 10: ONSE Target Results for **IR 2 - Quality of Priority Health Services Improved***

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
2-1. Number of newborns who received postnatal care within two days of childbirth in USG supported programs	116,178	815,285	532,913	65%	+416,735 newborns (359% increase)
2-2. Percent of suspected malaria cases tested by either microscopy or rapid diagnostic test	70%	95%	98%	103%	40% increase
2-3. Percent of pregnant women who received three or more doses of IPTp during ANC	41%	52%	55%	106%	31% increase
2-4. Percent of clients satisfied with quality of services	23%	45%	50%	111%	117% increase

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90%-99%)* *Achieved 100% or better of target*

*Table 10a: ONSE Target Results for **Sub-IR 2.1. Competencies of health service providers in targeted districts increased***

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
2.1-2. Number of individuals receiving malaria-related training (ACT, Case management, Lab diagnostics, IPTp)					
2.1-3. Number of individuals receiving family planning-related training (CBFP, LAPM, YFS)					
2.1-4. Number of individuals receiving WASH-related training (Water Resource management) SEE FINAL LoA TABLE					
2.1-5. Number of individuals receiving maternal and neonatal health-related training (CBMNH, BEmONC, HBB, KMC, COIN, ECEB, PAC)					
2.1-6. Number of individuals receiving child health-related training					

[Note that Length of Activity data targets and results for these indicators are not included in the Final Project Report.]

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90%-99%)* *Achieved 100% or better of target*

Table 10b: ONSE Target Results for ***Sub-IR 2.2. Quality Assurance systems in targeted districts improved***

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
2.2-1. Number of health facilitates that maintain international SPHERE standards for the treatment of severe acute malnutrition	136	230	268	116%	+132 facilities (97% increase)
2.2-2. Percent of confirmed malaria cases receiving first line antimalarial medication	87%	95%	100%	105%	15% increase

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90%-99%))* *Achieved 100% or better of target*

*Table 11: ONSE Target Results for **IR 3 – Performance of Health System Strengthened***

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
Sub-IR 3.1: Strategic management and supervision of human resources for health improved					
3-1. Percent of health facilities supervised based on performance standards in Integrated Supportive Supervision Tool that complete follow-up actions	40%	89%	79%	84%	98% increase
Sub-IR 3.2. District-level governance, management, and policy implementation improved					
3.2-1. Number of DIP reviews conducted to revise DIP activities or budgets with stakeholder	16	161	139	86%	+123 DIP reviews (769% increase)
3.2-2. Percent of health facilities with functional Health Center Advisory Committees	87%	96%	72%	0%	17% decrease
3.2-3. Number of health facilities that have implemented their facility level WASH action plan	0	131	142	108%	0 -> 142 facilities
3.2-4. Number of districts with an operational area mechanics network as a result of USG assistance	0	11	11	100%	0 -> 11 facilities
3.2-5. Number of districts regularly monitoring water point functionality as a result of USG assistance	0	11	11	100%	0 -> 11 facilities

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90%-99%)* *Achieved 100% or better of target*

Table 11a: ONSE Target Results for ***Sub-IR 3.3: Use of a health information system to inform management of district-level health services institutionalized***

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
3.3-1. Number of health facilities submitting data in line with national standards					
DHIS2	205	308	307	99%	+102 facilities (49.8% increase)
Open LMIS	308	388	388	100%	+72 facilities (26% increase)

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90%-99%))* *Achieved 100% or better of target*

Table 12: ONSE Target Results for ***IR 4 – Demand for quality priority health services increased***

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
4-1. Percent of population reporting unmet need for Family Planning, Nutrition, Maternal, Newborn and Child Health, WASH.					
Family Planning	18.7%	13%	13%	0%	30.5% decrease
EmONC	74.3%	74%	74%	0%	No change

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90%-99%))* *Achieved 100% or better of target*

*Table 12a: ONSE Target Results for **Sub-IR 4.1: Health-seeking practices and behaviors improved***

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
4.1-1. Number of pregnant women who initiate ANC visits in the first trimester	36,500	259,730	233,906	90%	+197,406 women (541% increase)
4.1-2. Number of facilities with low-literacy SBCC materials and/or messages for facility-based patient education and community mobilization	0	420	266	63%	0->266 facilities
4.1-3. Number of communities verified as "open defecation free" (ODF) as a result of USG assistance	0	2,720	3,280	121%	0 -> 3,280 communities
4.1-4. Percentage of targeted communities reporting access to improved sanitation products or services as a result of USG assistance	0%	80%	39%	49%	+39% of targeted communities
Number of people reached by a USG-funded intervention providing GBV services	N/A	344	510	148%	+510 people reached with GBV services Baseline not available.

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90%-99%))* *Achieved 100% or better of target*

Table 12b: ONSE Target Results for ***Sub-IR 4.2: Participatory processes for community empowerment to safeguard health improved***

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
4.2-1. Percent of health facilities with functional Health Center Advisory Committees	10%	45%	30%	67%	200% increase
4.2-2. Number of USG-supported activities designed to promote or strengthen the civic participation of women	0	26	67	258%	0 -> 67 activities
4.2-3. Number of civil society organizations receiving USG assistance engaged in advocacy interventions	N/A	327	257	79%	Baseline not available.
4.2-4. Number of Champion Communities established	0	100	127	127%	0 -> 127 Champion Communities established
4.2-5. Number of sanitation enterprises (e.g., Local masons) that have improved capacity in sanitation supply service delivery as a result of USG assistance	0	137	252	184%	0 -> 252 sanitation enterprises capacitated

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90%-99%))* *Achieved 100% or better of target*

Table 13: Integration

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
IN-1. Number of integration interventions completed	N/A	78	139	178%	Baseline not available

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90%-99%))* *Achieved 100% or better of target*

Table 14: Cross Cutting

Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
CC-1. Number of people reached by a USG-funded intervention providing gender-based violence services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other)	0	344	510	148%	0 -> 510 people reached
CC-2. Number of policy dialogues and advocacy with public, private, and community organizations to address gender bias in access to and quality of services	0	11	8	73%	0 -> 8 policy/advocacy dialogues held
CC-3. Number of women's groups, girls' groups, and youth groups supported to facilitate their role as change agents in their communities	0	243	821	338%	0 -> 821 organizations facilitated
CC-4. At least one FP compliance questionnaire completed for each project supported facility per year during supervisory visits	N/A	393	859	219%	Baseline not available.

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) Almost achieved (90%-99%) Achieved 100% or better of target

ANNEX 6: SMART CAPACITY BUILDING, HSS, AND CONTEXTUAL FACTORS ACCOMPLISHMENTS

Activity and Indicator	*Baseline*	*LOA target*	*Endline result*	*% LOA Target achieved*	*LOA Change from Baseline*
Smart Capacity Building					
Number of newborns not breathing at birth who were resuscitated in USG-supported programs	3,500	34,500	49,821	**144%**	+46,321 newborns (1,324% increase)
Number of newborn infants receiving antibiotic treatment for infection through USG supported programs	0	22,282	41,044	**184%**	0 -> 41,044 infants treated with antibiotics
Number of health facilities that maintain international SPHERE standards for the treatment of severe acute malnutrition	136	230	268	**117%**	+132 health facilities (97% increase)
Number of health facilities submitting data in line with national standards (DHIS2)	205	308	307	**98%**	+102 health facilities (50% increase)
Number of health facilities submitting data in line with national standards (Open LMIS)	308	388	380	**98%**	+72 health facilities (23% increase)
Number of children under five years of age suspected with pneumonia receiving antibiotics by trained facility or community health workers in USG-assisted programs	0	1,820,800	3,016,169	**166%**	0 -> 3.02 million <5 children
Number of basic sanitation facilities provided in institutional settings as a result of USG assistance	0	102	131	**128%**	0 -> 131 settings
Number of institutional settings gaining access to a basic drinking water services as result of USG assistance	0	78	85	**109%**	0 -> 85 settings
Number of facilities with improved infrastructure as a results of USG assistance	0	92	141	**153%**	0 -> 141 facilities
Number of health facilities that have equipment considered basic to quality client services available in the general outpatient service area	36	158	239	**151%**	+203 health facilities (564% increase)

Activity and Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
Health System Strengthening and Improved Access					
Percent of non-public health facilities (including CHAM, NGO, and private-for profit institutions) supported by USG to provide priority health services	46%	70%	77%	109%	67% increase
Couple Years Protection	675,000	4,590,000	3,828,930	83%	+3,153,930 CYP (467% increase)
Number of calls received through CCPF Health Hotline	656	65,656	79,226	121%	+78,570 calls (12,000% increase)
Percent of communities using Community Scorecard (CSC) methodology	30%	57%	60%	105%	100% increase
Number of Champion Communities established	0	100	127	127%	0->127 CCs established
Number of youth (10-24 years) utilizing youth-friendly health services in facilities supported with USG funds	105,000	1,505,000	3,805,512	253%	+3,700,512 youth (3,524% increase)
Number of USG-assisted community health workers (CHWs) providing family planning (FP) information, referrals, and/or services during the year	0	5,887	9,661	164%	0->9,661 CHWs providing FP
Contextual Factors Addressed					
Number of USG-supported activities designed to promote or strengthen the civic participation of women	0	26	67	258%	0 -> 67 activities strengthening civic participation of women
Number of civil society organizations receiving USG assistance engaged in advocacy interventions	0	137	252	184%	0 -> 252 organizations
Number of women's groups, girls' groups, and youth groups supported to facilitate their role as change agents in their communities	0	243	821	338%	0->821 female and youth organizations facilitated

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) *Almost achieved (90-99%)* *Achieved 100% or better*

Activity and Indicator	Baseline	LOA target	Endline result	% LOA Target achieved	LOA Change from Baseline
Contextual Factors Addressed					
Number of USG-supported activities designed to promote or strengthen the civic participation of women	0	26	67	258%	0 -> 67 activities strengthening civic participation of women
Number of civil society organizations receiving USG assistance engaged in advocacy interventions	0	137	252	189%	0 -> 252 organizations
Number of women's groups, girls' groups, and youth groups supported to facilitate their role as change agents in their communities	0	243	821	338%	+821 female and youth organizations facilitated
Number of people reached by a USG-funded intervention providing GBV services	N/A	344	510	148%	+510 people reached with GBV services

Source: AIDS-612-C-17-00001 ONSE FINAL PROJECT DRAFT 2022

Not achieved (0-89% of target) Almost achieved (90-99%) Achieved 100% or better

ANNEX 7: DISCLOSURE OF ANY CONFLICTS OF INTEREST

CONFLICT OF INTEREST (COI) VERIFICATION

(please fill/sign/date the form below)

Name:	Joseph N. Inungu
Title:	Team Lead
Organization:	ME&A, Inc.
Evaluation Position:	
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)*	
I have real or potential conflict of interest to disclose:	☐ YES ☒ NO ☐ NOT APPLICABLE
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.*	
Name and Signature: Joseph Inungu	*Joseph Inungu*
Date: 6/20/2022	

CONFLICT OF INTEREST (COI) VERIFICATION

(please fill/sign/date the form below)

Name:	
Title:	Team Lead
Organization:	ME&A, Inc.
Evaluation Position:	
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)*	
I have real or potential conflict of interest to disclose:	☐ YES ☑ NO ☐ NOT APPLICABLE
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.*	
Name and Signature: Kathe Bennett	
Date: 7/14/12	

ME&A

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

Name	**Tim Allen Clary**
Title	**Consultant – Team Lead**
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)*	**GH EvaLS 025 Malawi Organized Network of Services for Everyone's Health End Line Performance Evaluation activity**
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.*	

Signature	Tim A. Clary	
Date	1/25/2023	

CONFLICT OF INTEREST (COI) VERIFICATION

(please fill/sign/date the form below)

Name:	Martha Benezet
Title:	Consultant
Organization:	ME&A, Inc.
Evaluation Position:	
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)*	
I have real or potential conflict of interest to disclose:	☐ YES ☑ NO ☐ NOT APPLICABLE
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.*	
Name and Signature: Martha Benezet	
Date: 7/19/12	

CONFLICT OF INTEREST (COI) VERIFICATION

(please fill/sign/date the form below)

Name:	**Shabnam Shahnaz**
Title:	Consultant
Organization:	ME&A, Inc.
Evaluation Position:	Consultant
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)*	
I have real or potential conflict of interest to disclose:	☐ YES ☐ √ NO ☐ NOT APPLICABLE
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.*	
Name and Signature: Shabnam Shahnaz Shabnam Shahnaz.	
Date: 08.04.2022	

PART III – APPENDICES

ME&A

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

Name	Robert Waswaga
Title	Consultant – **Evaluation Specialist**
Organization	ME&A, Inc.
Evaluation Position	**Evaluation 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)*	**GH EvaLS 025 Malawi Organized Network Of Services For Everyone's Health End Line Performance Evaluation activity**
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.*	

Signature	
Date	25/11/2023

ANNEX 8: EVALUATION TEAM

Joseph Inungu: Co-Team Lead

Joseph Inungu is a professor of global health in the School of Health Sciences at Central Michigan University (CMU). He is the founding Director of the Master of Public Health Program at CMU. Before joining CMU, he served as the Director of socio-behavioral research for the International AIDS Vaccine Initiative (IAVI) in Southern Africa. IAVI is a New York-based NGO specializing in HIV vaccine research. Prior to joining IAVI, he worked as the Regional Researcher for Population Services International (PSI) in West and Central Africa. He provided technical assistance and oversaw the design and implementation of social marketing research in six African countries including Benin, Burkina Faso, DR Congo, Liberia. Nigeria, and Senegal dealing with the prevention of HIV/AIDS and Malaria, RH, water, sanitation and hygiene. He conducted program evaluations and capacity building in conducting research in participating countries. Dr Inungu authored more than 50 articles in peer-reviewed journals and presented several papers at national and international conferences. He co-authored the textbook titled Foundation of Rural Public Health in America published by Jones & Barletts Learning in 2022. He holds a Master's and a Doctor of Public health degrees from Tulane University School of Public Health and a Doctor of Medicine degree from the University of Kinshasa in DR Congo

Tim A. Clary (M.A., EMBA, M.S./Ph.D.), Co-Team Lead

Dr. Tim A. Clary is an independent consultant who focuses on international health and development. An infectious diseases epidemiologist by training, he has provided consulting services for organizations such as USAID, PEPFAR, the Global Fund, several United Nations agencies, the World Bank, the International Finance Corporation, GIZ, the U.K. Department for International Development, and several nongovernmental organizations. His consulting assignments have taken him to more than 65 countries in all geographic regions of the world. From 2011–2013, Dr. Clary was the Director of Health for the Millennium Challenge Corporation. During that time, he oversaw a portfolio of approximately $300 million in USG investments in health, including a $131.5 million nutrition, maternal, and child health and results-based financing initiative in Indonesia; a $120.5 million HSS and HIV/AIDS project in Lesotho; and a $38.5 million noncommunicable disease and injury program in Mongolia. From 2000–2006, he was with USAID, first as the HIV/Infectious Diseases Epidemiologist for Europe and Eurasia overseeing several grants, cooperative agreements, and contracts, and then as a Senior Public Health Advisor for USAID/Ukraine. During his time in Ukraine, Dr. Clary designed, developed, and oversaw several projects covering infectious diseases, RH, maternal and child health, and birth defects for Ukraine, Belarus, and Moldova. Prior to his work with USAID, Dr. Clary was with the U.S. Centers for Disease Control and Prevention's Office of Research Methodology.

Martha Benezet, Evaluation Specialist

Martha Benezet is a senior technical advisor and activity leader with 18+ years strengthening national and sub-national systems and building capacity for quality, evidence-based health service delivery in 17 African and Asian countries. She has held leadership roles in the targeted design, management, assessment and evaluation of complex national and sub-national Global Fund, USAID-, PEPFAR-, and MCC-funded health programs, with focus on innovative, cost-effective solutions and expertise in HSS. Prior to her current role with USAID GH EvaLS as an Evaluation Specialist, she was the Director of Global Monitoring, Evaluation, Learning and Communications for the USAID Infectious Disease Diagnostics and Surveillance Activity at ICF International and also a Senior MEL Advisor at University Research Co., LLC (URC). Earlier, she spent 7 years at Abt Associates as a Senior Associate and TB

Strategic Lead, providing cross-activity team leadership and technical support for health systems, nutrition, and infectious disease research, health policy development and service delivery activities. Martha began her international career as the TB-HIV Program Manager in South Africa for Medical Care Development International. She has an M.S. in Food Policy and Applied Nutrition from the Friedman School of Nutrition Science and Policy at Tufts University in Boston, Massachusetts.

Shabnam Shahnaz, Evaluation Specialist

Shabnam Shahnaz is a senior manager and technical consultant with more than 30 years of experience in developing and managing international Health, Population and Nutrition programs and activities. She is a specialist in reproductive health particularly in the activities related to the reduction of maternal morbidity and mortality (with special focus on Maternal, Neonatal and Child Health; Adolescent health, FP; Birth Spacing, Post-Abortion Care, Emergency Obstetric Care, and STDs/ HIV/ AIDS) and Child Survival, Primary Health Care (Immunization, ARI, CDD, integrated management of childhood illness, Nutrition), Infectious diseases (tuberculosis and malaria). Her experience entails conceptualizing, designing, implementing, and evaluating complex national, regional and global programs in more than 10 countries in Asia, Europe, and the Arab World during her work with Pathfinder International, UNICEF, Plan International, Marie Stopes International. She worked for Pathfinder International in different capacities Since her work with Pathfinder, she has served as the activity officer for the Women's Right to Life and Health Activity with UNICEF and then Regional Director of South Asia, Arab World and East Europe Programs with Marie Stopes International. Shabnam holds a MD from the Lady Hardinge Medical College, University of Delhi, India and an MPH from the University of North Carolina at Chapel Hill, USA with the focus on Health Policy and Administration. She is also a Fellow of the Royal Society for Public Health, United Kingdom. She also has training in leadership, management, quality and performance improvement, service improvement and systems development. Before her current role with USAID GH EvaLS as a Subject Specialist, she has been involved with Chemonics, RTI as technical advisor to support and contribute to business development activities for USAID and DFID activities.

Robert Waswaga, Data and Evaluation Specialist

Mr. Waswaga is an economist and evaluation practitioner with more than 20 years of experience in international development. He has provided consultancy services in monitoring and evaluation for 18 years, including 97 program evaluations, 53 baseline surveys, and 47 organizational assessments amongst other assignments. Mr. Waswaga's sector consultancy experience covers areas such as maternal, neonatal and child heath, adolescent SRHR, food security, WASH, basis (primary) education, and other sectors. He has provided consultancy services to government and non-governmental agencies operating in Uganda, South Sudan, DR Congo, Kenya and Tanzania. Some of his clients have included the Government of Uganda, Norwegian Refugee Council, World Vision International, Build Africa Uganda, Save the Children International, ChildFund International, SightSavers, Plan International, the Belgium Technical Cooperation Agency, USAID GH EvaLS, AMREF Health Africa, and War Child Holland and United Kingdom. Mr. Waswaga is currently finalizing a Master of Philosophy in Programme Evaluation (dissertation stage) at University of Cape Town, South Africa. He holds Masters of Arts in Economic Policy Management, Bachelors of Arts Degree (Economics/Social Anthropology)-Second Class Upper Division, Certificate in Health Systems Research, July 2022 (Makerere University College of Health Sciences' School of Public Health).