

**USAID/Angola
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Task order No. GHS-I-08-03-00025-00**

**Angola Essential Health Services Program
Task Order Contract**

CORE Component

Prime Contractor:

Chemonics International Inc.

Subcontractors:

**JHPIEGO
MIDEGO
Harvard School of Public Health**

**Authorized period of performance as of effective date (9/30/2006):
9/30/2006 – 9/29/2009**

ARTICLE 1 INTRODUCTION

The U.S. Agency for International Development is acquiring technical services for implementing the Angola Essential Health Services Program/Servicos Essenciais de Saude (SES) and achieving USAID/Angola's Strategic Objective 11, *Increased Provision of Essential Services by Local and National Institutions*.

ARTICLE 2 BACKGROUND

Although referred to as a recovering state in USAID/Angola's strategy statement, Angola nevertheless remains in the fragile state category. Among the sources of Angola's fragility are: weak governance undermined by 500 years of colonialism and decades of civil war; outstanding issues of political and civil reconciliation, complicated by large groups of returning citizens who are just starting the reintegration and healing process; war-damaged infrastructure hindering access to key social services in most of the country; and a young, immature civil society.

The health sector has a critical role to play in addressing sources of fragility. By providing quality health services for everyone, especially the poorest and previously underserved populations, health sector institutions can reduce vulnerability among populations and hasten recovery from conflict. USAID/Angola has emphasized the crucial role that strong health sector institutions play in diminishing fragility by including health interventions as an important element of its strategy through Strategic Objective (SO) 11, *Increased Provision of Essential Services by Local and National Institutions*. SO11 is part of the integrated approach to address sources of fragility in Angola, which also includes activities in governance reform and economic development under SO9 and SO10. Combined, they contribute to the goal articulated in USAID's fragile state strategic framework for Africa: "Manage Crises and Promote Sustainability, Recovery and Democratic Reform."

ARTICLE 3 OBJECTIVES OF TASK ORDER

As the principal health program for USAID/Angola, the Essential Health Services/Serviços Essenciais de Saúde (SES) Project aims to address Angola's fragility by seeking to establish stability in the short-term through improved health service delivery at the community, municipal and provincial levels in selected provinces. To maintain this stability and promote a more transparent and prosperous society over the longer term, the project seeks to strengthen health sector governance through human capacity development and systemic reform efforts. These goals will be achieved by expanding delivery and improving quality of health services in three provinces (Luanda, Huambo, and Lunda Norte); improving health systems such as procurement, data management, supervision and quality control, and program monitoring; and fostering community outreach and local participation in health decision making. The project seeks to reduce maternal, newborn, and child mortality through improved reproductive health (RH) practices and prevention and treatment of malaria, TB, and HIV/AIDS. The results framework in Annex B shows key results areas (KRAs) that break down the program components into priority results to achieve SO11. Some of the activities will also contribute to the USAID Missions' governance and economic opportunities objectives (SOs 9 and 10).

ARTICLE 4 SCOPE OF WORK

The statement of work is conceived as a five-year effort, with a three year base period, followed by a two year option period which depends on successful implementation of the deliverables in the base period. In addition, the program has two components: the Core SES Program and HIV/AIDS activity option. Exercise of the HIV/AIDS activity option will be provided annually depending on availability of funds and successful implementation of activities and deliverables schedule for previous years.

The Contractor must achieve targeted results set forth below which in turn, will promote achievement of the objective of this Task Order as stated above. The implementation responsibilities of the Contractor are defined by each targeted result, and are subject of both the contractor’s annual workplan and the performance monitoring/management plan (PMP), against which the Contractor performance shall be evaluated. The determination of successful performance shall be based upon the achievement of the desired results and not merely the generation of activities.

4.1 DETAILED TECHNICAL REQUIREMENTS – CORE ESSENTIAL HEALTH SERVICES PROGRAM(SES)

The Contractor must perform all tasks under each Targeted Result as described below:

a) Targeted Result No. 1 Targeted local national and local institutions delivering quality services (IR:1)

Priority Results	Long-term Impact
Providers trained to provide integrated services	Priority interventions provided at the local level
Community satisfied with services	More families using health services
Referral system functioning	Increased demand for primary health care at the community level

Overview/Strategy: This task addresses increasing the health care provider’s ability to improve the availability and quality of priority services at all levels. Health care providers from public and private sectors will provide a set of interventions—including diagnosis and treatment for malaria and TB and better information and services for FP to impact maternal and child morbidity and mortality.

The Contractor must train a core group of master trainers to use the Standards-Based Management and Recognition (SBM/R) tool (see box) to set standards at facility level for integrated provision of MCH and RH/FP services. For example, antenatal visits should include intermittent presumptive treatment for malaria, counseling about abstinence and consistent condom use, birth spacing education,

- | SBM/R Steps |
|--|
| <ul style="list-style-type: none"> • Setting operational performance standards • Implementing the standards • Measuring progress • Recognizing achievement of the standard |

- | Master Trainer Incentives |
|---|
| <ul style="list-style-type: none"> • Recognition of achievement: MOH and provincial directorates attend graduation and certification ceremony • Job evaluation: incorporate contractual and performance terms in job descriptions • Monetary incentives: SES will approach companies to sponsor competitions that award trainers who certify the most <i>Centros de Exelência</i> (see IR2) |

and distribution of nets, medicines. Trainees shall receive an update in evidence-based MCH/RH health care practices, including diagnosis and treatment of malaria and TB. They shall then be coached in leadership skills to enable them to implement these standards at their facilities. The training shall also include baseline and internal monitoring assessment, standards for supervision, management, accounting and reporting, as well as community outreach.

The providers will then be able to: advocate changes in MCH care practices, articulate the evidential basis for such changes, teach and train at the in-service and pre-service level, and provide leadership to improve the MCH care. The Contractor must accompany master trainers to the training sessions at the health centers and health posts and will provide feedback. The trainees shall be selected from the public sector and NGOs and will become qualified to train health care providers at health centers and health posts operating in their municipalities. The Contractor must train 75 master trainers from the public sector in the first **26** months of the project, as well as 15 master trainers from NGOs. Thirty more master trainers from the NGO sectors shall be trained in the second year.

As part of the SES training, the experts will commit to an action plan to improve selected MCH care practices at their respective institutions, as well as in the health centers and health posts in their municipalities. In order to ensure that the master trainers continue to practice and train other trainers using SES methodologies the Contractor must work with MOH and provincial directorates to introduce a number of incentives (see box). The Contractor must also set aside a training fund to help master trainers with follow-up training.

KRA1.1: Improved and integrated quality health service delivery standards

Task No. 1 Protocol review, update and curriculum development.

The Contractor must facilitate a workshop to discuss and review the current protocols on RH/FP, MCH, TB, and malaria already developed by several donor-funded programs within MOH. Stakeholders will include MOH representatives from the national, provincial and municipal levels, NGOs and private sector companies, associations such as CONGA and FONGA, women's groups, and key community-based organizations. The Contractor must work on updating and integrating these protocols into one comprehensive package for health centers and health posts, addressing issues such as provision of FP information at antenatal visits and distribution of nets at public health facilities. Simultaneously, the Contractor must review all existing NGO community outreach and education manuals against the national norms and work on updating and finalizing with MOH community outreach protocols.

Master Training Curriculum

- Integrated performance standards and protocols for MCH, FP counseling and diagnosis and treatment of malaria and TB
- Gender and youth sensitivity
- Baseline and internal monitoring
- Supervision and implementation skills
- Management, accounting, reporting
- Medical waste disposal
- Community outreach skills
- Advocacy for health budgets

KRA1.2: Improved, integrated quality services offered

Task No. 1 Training of core group of master trainers.

The Contractor must work with MOH and counterparts to plan and coordinate 10-day trainings of core teams in setting and implementing standards of service delivery over **26** months, covering 90 people. The trainees shall be chosen from the provincial directorates, supervisory staff from the municipalities, directors of programs, service delivery NGOs, and proven master trainers.

Task No. 2 Follow-up on implementation of norms and standards of quality service delivery at health centers and health posts.

Core master trainers shall train health supervisors, who in turn will train health workers at the health centers and health posts and clinics, using an integrated training package described above that includes clinical skills in diagnosis of malaria and TB, FP counselling, management and supervisory skills, and accounting and reporting. The Contractor must observe the quality of training delivered by the master trainers and provide feedback. With coordination and support of provincial coordinators, the Contractor must monitor the implementation of standards of quality service delivery at selected health centers and health posts, measuring all aspects of service delivery against SBM/R standards and providing on-the-job training and mentoring. These follow-up activities will inform any changes required in the protocols and curricula. **Through the Angolan Business Alliance against HIV AIDS and other business coalitions, the Contractor must explore possibilities for leveraging funds from the private sector to support this cascade training system (e.g. transportation and meals for master trainers) and extend the coverage that would be otherwise possible with USG resources.**

Task No. 3 Training of community-based health education and liaison workers including traditional birth attendants (TBAs).

Based on the protocols and the new curriculum developed for the outreach workers, the Contractor must train community health volunteers (CHVs), TBAs, and NGOs and CSOs, particularly faith-based, women, and youth groups, in delivering health education messages, including those that have already been developed (i.e. by Advance Africa in Huambo), related to proper diagnosis, treatment and referral of malaria and tuberculosis, as well as FP. Training for TBAs may include referring women to health facilities.

Task No. 4 Piloting a functional referral system.

A referral system to help refer mothers and children to appropriate levels for services is important in reducing maternal and infant mortality. It would also increase demand for primary health care in the community and relieve unnecessary burden on hospitals. Angola's 2005 health system assessment noted that a proper health care delivery referral system is either weak or non-functioning. The Ministry Health Department of Public Health views this as a priority. Based on the results of the situational analysis, the Contractor must work with the provincial public health directorate to define standards of service delivery for each level of primary health care services using SBM/R. This will help determine what services will be provided at each level. The Contractor's efforts must be coordinated with donor programs that provide funding for transportation and equipment necessary for implementation and approach the **business coalition** to leverage both ideas and funds that will contribute to a referral system that integrates private sector resources and needs.

b) Targeted Result No. 2 Targeted national and local institutions with improved

capacity to plan, manage and monitor systems

Priority Results	Long-term Impact
Adequate resources allocated for pressing health needs	<ul style="list-style-type: none"> • Transparency and decision making • More families have access to health care
Decrease in stock outs	Malaria, TB, and FP commodities available to families in communities
Better quality, more reliable services	Primary health care needs are met at the community level

Overview and approach: Enhanced MOH institutional capacity to plan, manage and monitor programs, including information and decision-making linkages between all levels of health administration will help expand essential services, improve provider performance, and reach more underserved Angolan women and children. Since the civil war, there has been a lack of technical capacity to collect, analyze and report data. Weaknesses in the commodity and distribution systems lead to stock-outs, weakening faith in the public system.

The Contractor must apply SBM/R to set standards in logistics and procurement management, data management, planning and budgeting, and monitoring and supervision of service delivery. SES' master trainers shall then assist with setting and implementing these standards at all levels, and train health supervisors and health workers. The Contractor must use a simplified procurement approach and provide intensive training for 30 staff from provinces, municipalities, and the central level in standards for logistics and procurement in the three provinces over the first 26 months, and an additional 30 people shall be trained in standards for health management information systems (HMIS) and data analysis.

KRA 2.1: Data collected, managed and utilized in program planning

The Contractor must take the following steps to promote an environment of informed decision making and vertical information linkages between all levels:

Task No. 1 Building capacity of provincial and municipal staff in data analysis and reporting.

The Contractor must undertake a targeted situational analysis of management and reporting systems and skills in the target provinces, building on findings outlined in the PHR plus Angola Health System Assessment. The Contractor must work with targeted directorates to build skills in analyzing data to recognize trends and warning signs and take appropriate measures or report them in a timely manner to the next level. The Contractor must use the SBM/R approach to set standards. The Contractor must provide assistance in designing new data collection and reporting tools, including replacement of data on vertical programs with integrated health reports from the provincial level to the HMIS at the National Directorate of Public Health.

At the central level, the Contractor must work with MOH, in particular the Cabinet of Planning, Studies, and Statistics to assess impediments to informed decision making, including quality of information from the bottom and mid-levels, systems of information flow at the central level, and central level capacities for receiving and analyzing data from multiple sources and using it. The Contractor must develop and implement a plan over the course of three years for assistance in areas identified in this assessment through competency-based training, on-the-job coaching,

and mentoring in MOH, all three provincial directorates, and pilot municipalities. The Contractor must discuss with USAID, MOH, and project private sector counterpart's options for leveraging the funds for implementing these activities with funding from other programs working on these issues, such as EU, UNDP, WHO, etc.

KRA 2.2. Improved planning and budgeting at municipal and provincial levels

Task No. 1 Strengthening capacity to develop and advocate budgets and operational plans for health at provincial level and municipal levels.

The Contractor must initiate sessions with EU, UNICEF, and other donors and identify areas where SES can best complement what has been accomplished by ongoing programs. One possible aspect is building capacity in advocating for budgets and resources to implement health plans; another is building community outreach skills for receiving input from community during planning and budgeting. The Contractor's SBM/R modules shall include standards for information flow between municipal and provincial and provincial and central levels to inform budgeting and planning, competencies for data analysis in developing plans and budgets, allocation of user fee revenues, and linking budgets to operational plans and vice versa.

KRA2.3. Improved logistics and procurement management

Task No. 1 Strengthening National Essential Drug Program.

The Contractor must work with targeted provinces and municipal directorates to assess, analyze and address key issues involved in procurement of essential drugs including transparency, accountability, and implementation of proper distribution standards. The Contractor must assist the Directorate of Drugs and Equipment in developing a national pharmaceutical policy that will ensure quality assurance mechanisms, national formularies, drug registration policies, or any overarching regulatory framework and work with UNFPA to incorporate lessons learned on strengthening the National Essential Drug Program.

Task No. 2 Action planning for procurement and logistics assistance.

The Contractor must work with the MOH's Directorate of Drugs and Equipment to review the assessment of the procurement system, recently carried out with support from UNICEF. If the report is not yet available, an initial assessment shall be conducted by the Contractor to consider verifiable forecasts needs, commodity composition, usage data, provider and client awareness of use and application, delivery systems and problems, existing inventories, inventory management, and waste disposal practices in the targeted provinces/municipalities. The PHR plus assessment has already identified that there is a need to establish a standard procurement cycle. The Contractor must discuss the development of the plans to help establish a simplified and integrated procurement and logistics system with USAID and the MOH. Assistance could include strengthening the operational soundness of MOH's procurement system; piloting a simplified procurement cycle; and building capacity in skills at all levels to implement such a system.

Task No. 3 Establishing simplified procurement process at targeted facilities.

The Contractor must develop an innovative, streamlined and FAR-compliant procurement process. This will involve establishing and maintaining in targeted municipal health authorities a simple forecasting system that will periodically review inventory levels, usage data, and distribution figures, thereby generating a reasonably accurate forecast of requirements. The forecasts shall be translated into specific lists of needs, identifying item-by-item the

procurements to be conducted, providing clear and non-restrictive specifications, and specifying firm delivery dates. To further speed up the process, provisions will be made to restrict procurements to local and regional sources, periodically alerting them to forthcoming procurements. Procurements will be conducted, if possible, under informal solicitation rules, with a short offer deadline and under a clear and simple solicitation notice. Offers will be evaluated promptly and awards made on the basis of responsiveness, and price.

Task No. 4 Integrated procurement and logistics training for the targeted provinces and municipalities (see box).

In order to implement a simplified procurement process, the Contractor must provide procurement and logistics training for 30 participants—procurement and logistics staff and supervisors from the provinces, municipalities, and the Department of Drugs and Equipment. At the same time, SBM/R training for health care providers shall give them basic skills in planning supplies that they need. Training will be followed up with case studies to document inventory control and procurement, and follow up coaching will be provided as needed.

Procurement and Logistics Training

- Basic elements of accurate forecasting
- Competitive procurement
- Storage, distribution and inventory control
- Avoiding stock-outs
- Proper disposal

Task No. 5 Development and implementation of guidelines regarding determination and posting of user fees at health facilities, and uses to which health facilities may allot these resources.

The Contractor must present to the MOH the optimal way for allowing the health care facilities to generate budgets for operating expenses, either through user fees or other financing mechanisms, be it allocations from federal budget, local governments, or community financing schemes. The Contractor must undertake a literature review on user fee and alternative financing mechanisms in other countries in Africa and also work with the MOH to do a study in targeted provinces to document how user fees work in Angola and what the main constraints are that prevent uniform implementation of user fees in different service delivery settings throughout the country. Additionally, the Contractor must explore alternative mechanisms for health financing. The results of the studies on user fees and alternative financing mechanisms shall be presented, and the recommendations on the optimal option shall be made to the MOH, with subsequent assistance in implementing health financing mechanisms in selected municipalities.

KRA 2.4. Improved capacity to monitor and supervise the quality of health service delivery

Task No. 1 Improved supervision of health center operations.

The Contractor must assist the provincial and municipal health directorates in developing and implementing quality assurance/performance improvement plans; setting specific indicators to measure the quality of each program; and supporting development of an integrated supervision system in which supervisory activities look at an integrated package of health services. The SBM/R training of master trainers shall include modules related to supervision. The Contractor must follow up this training with on-the-job coaching of selected supervisors in targeted municipalities on measuring performance of health centers against standards set with the help of SBM/R. The Contractor must facilitate mystery client interviews and focus group discussions with the community. Per the MOU, the MOH will officially recognize the quality health centers

as *Centros de Exelência* and the supervisors of these centers will receive special recognition for their efforts. The Contractor must also investigate using the **corporate business coalition** as a vehicle to finance awards to trainers that certify the most *Centros de Exelência*.

c) Targeted Result No. 3 Increased individual and civil society's knowledge and practice of positive behaviors (IR:3)

Priority Results	Long-term Impact
Health workers, NGOs, CSOs, and private companies understand the factors that influence behaviors and get the right messages out	<ul style="list-style-type: none"> • Pregnant women receive 2 doses of IPT • Pregnant women attend antenatal visits • Birth attended by skilled providers, Children and pregnant women sleep under ITNs
Communities know about the services provided and importance of the services	<ul style="list-style-type: none"> • Average age at first sex increase, number of partners decrease • People practice birth spacing • Patients follow adequate TB treatment norms

Overview/Strategy: Raising community awareness of healthy behaviors will increase demand, ownership and use of life-saving services. The Contractor must create partnerships between local health facilities and communities, work with local community leaders (*Sobas*) to identify health volunteers in the targeted communities, develop grassroots advocacy strategies for NGOs and CSOs, implement training on integrated community outreach protocols for health care providers from public and private sectors, and conduct information exchanges to promote best practices and share lessons learned for behavior change at regional, national, and international levels.

The Contractor must undertake formative research to understand the actual behavior and practices that the program will implement and get feedback from the providers and clients as to their overall satisfaction with the program, and incorporate traditional IEC campaign approaches such as radio, theater, and drama. To facilitate workplace programs in the private sector, NGOs, and CSOs, the Contractor must create an environment of mutual support and information exchange that will attract firms and NGOs to engage in the provision of health care-related services, including FP.

KRA 3.1. Increased health facility/workplace based outreach and health promotion

Task No. 1 Design and supply of health information materials.

The Contractor must review the proceedings of the health education workshop that was organized on May 9, 2006 by the Department of Health Education at the Directorate of Public Health with support from UNICEF on existing IEC materials and programs. The Contractor must then organize a three-day working group meeting that will include representatives from the health education department of each targeted province, and local NGOs, and CSOs to review and update the existing materials that are being used to spread health education information messages related to malaria, TB, birth spacing, safe birth, breast feeding and male involvement against updated community outreach protocols discussed under IR1. Although multiple IEC

materials have already been developed, due to lack of funds MOH has not been able to print and distribute them freely to the health facilities at the province and municipal level. During the workshop, participants will review these materials and discuss what additional funds are needed to distribute them in the targeted provinces and how to make these funds available. **By the end of the first three months, the Contractor must have begun working with the Business Alliance against HIV AIDS (CEC acronym in Portuguese) a newly formed business coalition founded by Odebrecht, USAID and the National HIV AIDS Institute, to develop a work plan for sharing of health education materials and strengthening corporate workplace programs, discuss methods of integrating proven materials into workplace programs, sharing lessons learned in workplace health programs, and develop co-funding strategies to share reproduction and distribution costs with the public sector.**

Task No. 2 Development of new health information materials.

To develop new materials that would integrate information on malaria prevention, ABC and VCT, birth spacing, and where and how to access services, the Contractor must undertake formative research to pre-test the messages with community health care providers and the clients. Once messages are tested, the Contractor must facilitate printing and distribution of the materials—leaflets, posters, booklets, and charts with diagrams that are easily understood by those who cannot read—through the trained CHVs, TBAs, and local community leaders (see IR1).

Benefits of the Business Coalition and its Technical Advisory Group

- Access to SES certified master trainers
- Assistance with IEC/BCC materials
- Public acknowledgement of efforts
- Quartely forums to share and standardize materials
- Clearing house for grants from CSOs to implement health outreach activities

Task No. 3 Build capacity of health care workers for effective and systematic use of community-based volunteers.

As described in IR1, the Contractor must provide integrated training to 75 health workers in clinical and non-clinical skills, including community outreach and health education. These master trainers shall be positioned to train health providers at the community level, guided by the Contractor. In addition, in Month 9, the Contractor must start orientations for health workers at the health centers on the use of community volunteers for IEC. At these orientations, the Contractor must encourage health providers to identify community volunteers (e.g. mothers interested in health issues) through home visits, which are part of the health workers' responsibility.

Task No. 4 Technical assistance and training on proven methods of IEC to Angolan companies to improve their workplace health programs.

Engaging the private sector to help steward positive messages in the workplace will require both diplomatic and technical skills. During the first **three** months, the Contractor must help develop an Angolan technical advisory group within the context of the Chevron-Odebrecht initiative to create a business coalition for HIV/AIDS and other health issues to galvanize support for health issues affecting companies and surrounding communities. By Month 6, the Contractor must discuss with the coalition founders cosponsoring of the private sector "summit" to demonstrate benefits of workplace programs and generate private sector support for workplace programs. Human resource and finance directors from **20-30** Angolan companies identified by the Contractor in consultation with the Cognizant Technical Officer, will be invited. Companies will include those that do not have workplace programs (while many multinational companies have both comprehensive health services and workplace programs, many SMEs do not); those who would like to enhance existing programs; and those who already have strong

workplace programs in place, such as Esso, Chevron, Coca-Cola, Odebrecht and could provide their insights to the discussion on lessons learned and best practices. During the summit the companies will be encouraged to join the business coalition (see box on previous page). The Contractor must encourage companies with existing strong programs to participate as mentors to others on development of workplace programs, to become reference sites for best practices and help companies develop and implement action plans to initiate or expand their workplace programs or replicate them through mentor or subcontractor relationships with in-country suppliers or distributors; determine methods of linking with the national and local referral system; and adapt IEC/BCC materials already developed for community consumption to create more demand and use of health services offered.

By month 6, the Contractor must develop a sub-grant, not to exceed \$50,000 that will enable the CEC, represented by the firm Odebrecht, to carry out the following activities:

- Develop joint training and IEC materials to be used by partners under the CEC;
- Support prevention and counseling training sessions for corporate AIDS promoters-activists;
- Provide state-of-the-art information on counseling, stigma issues and prevention for corporate human resources departments and management;
- Organize corporate events to recognize World AIDS Day and other symbolic dates;
- Design community/family outreach materials to promote prevention, VCT and other services to corporate workforce dependents;
- Co-Sponsor mass media promotional spots with the MOH/INLS;
- Stimulate and replicate particularly successful corporate initiatives.

The Contractor will leverage the experience and energy that leading companies have already taken to address workforce HIV interventions and corporate social responsibility generally. This partnership will be used to persuade other private sector partners to follow suit. The alliance will aim to improve workforce policies, share experiences and act as a conduit of information between those that have already developed strong in-house programs and those that wish to begin or strengthen their programs. It will provide a forum for addressing issues such as stigma, management responses to HIV, and company medical care and treatment. It will also ensure that companies just entering into the realm of HIV/AIDS programming have access to accurate and up to date information, as well as links to mentor-like programs.

Through this program, the Contractor, with a relatively small resource allocation, must leverage substantial and sustainable private sector resources to address HIV/AIDS among a very important target population. USAID will encourage CDC and other USG agencies to provide technical assistance as appropriate to adapt existing training materials and technical strategies to fit the Angolan private sector situation. The Contractor must monitor inputs including training of workforce personnel in behavior change, voluntary testing, and pre-and post-test counseling; assistance with design of a condom promotion strategy for most at-risk populations, and preparation of annual/multiple year budget estimates for the corporate alliance CEC. Once design of technical programs is complete, the companies will assume full responsibility for costs and implementation of the efforts.

Task No. 5 Knowledge-sharing activities for key health personnel in areas with successful community reach activities and national conferences.

At the end of Year 1 the Contractor must work with MOH and its counterparts to identify key officials and corporate partners who would travel to neighboring countries (e.g. Mozambique, Zimbabwe and Madagascar) on a study tour to visit some of the successful community

mobilization projects and replicate lessons learned. Some high-level officials will be encouraged to go on a study tour to Brazil to see the Family Health Program. In Years 2 and 3, the Contractor must organize national and regional conferences within the country to share best practices, lessons learned from successful models. Both the study tours and the national conferences will be key moments when high-level officials and decision makers can share what works and what doesn't. Participants in both the study tour and national conference shall be required to develop practical municipal and provincial-level recommendations and action steps to share the knowledge they have gained and implement achievable annual goals related to community outreach and behavior change.

KRA 3.2. Increased uptake of positive health behaviors

Task No. 1 Follow-up through client-customer satisfaction survey.

In addition to testing health messages, the TIPs approach is an excellent tool for health authorities and program planners in NGOs and the private sector to get feedback from clients and customers on the acceptability and utilization and obstacles they face in improving their health, and their motivations for trying new behaviors. Ultimately, this survey will inform how IEC/BCC materials can be further refined to reach more community members and create more client demand. TIPS also includes client interviews to provide information on quality of services. The Contractor must design the TIPs survey and test it in initial selected facilities /communities and work with municipal and provincial level officials, along with provincial coordinators, to collect and analyze survey data.

d) Targeted Result No. 4 - Increased individual and civil society's demand for and participation in improving quality and health services(IR:4)

Priority Results	Long-term Impact
Communities and health facilities partner to address health issues and improve services	<ul style="list-style-type: none"> • Increased transparency and responsiveness of health care system • Increased access to quality services for families in communities

Overview and approach: This task is aimed at creating awareness and ownership of the communities over their own health. It will also increase transparency and responsiveness of the health care delivery system and provide an opportunity for local communities to be responsible for monitoring the quality of services provided by the public sector, NGOs, CSOs, and private companies.

The Contractor must apply the Champion Community approach to organize and build capacity of Champion Community Committees with participation from the public and private sectors, NGOs, and CSOs from the health sector as well as environment, finance, governance, and economic development sectors. The committees draw up action plans and, implement initiatives

to improve maternal, child, and family health and address other community issues. The Contractor must also engage Angolan NGOs that specialize in health services provision into partnerships with public health facilities in order to improve quality of services and increase demand. Corporate partners shall also be tapped to co-fund initiatives such as demand generating campaigns or recognize champion community achievement.

KRA 4.1. Increased civil society's participation in quality improvement of health services

Task No. 1 Design of community outreach protocols for use at health centers and health posts.

Within the SBM/R framework, the Contractor must develop standards for community outreach by health facilities, building on existing protocols and best practices from other countries. For example, community networks of mothers with young children, males, and single females should be tapped as conduits of information and promoters that can build a critical mass of behaviors to establish norms. The standards will include provisions for receiving inputs from the public on decisions about health services and will need to be approved by MOH. Training of health workers and health staff in target municipalities will take place in months 10-26 in all targeted municipalities by master trainer. The Contractor must assist master trainers with training and follow up. IEC materials developed by SES as part of IR3 activities shall be distributed at the health centers and posts.

Task No. 2 NGO-health facility partnerships.

The Contractor must identify groups that are interested and capable of assuming the task of managing a local public health facility, including implementation of SBM/R standards, on-the-job coaching of its staff in service delivery, and community outreach. The Contractor must discuss this with MOH and the provincial directorates to gauge their support, articulating the value of such initiatives. With the Ministry's approval, the Contractor must test such partnerships in some of the municipalities in the beginning of Year 2, and roll out the model with any necessary improvements to the rest of the municipalities in Year 3. Success will be determined by improvements in the quality of services and increased use of the health facility by the families in the community. Additional initiatives to promote partnerships between health facilities and communities could include internship programs, where young people are placed within facilities or our partner NGOs to assist with research, outreach, and peer education initiatives. The Contractor will also coordinate CSO-NGO partnership opportunities with USAID's Civil Society Strengthening Program (CSSP), implemented under a cooperative agreement by the NGO World Learning. *The Contractor will also coordinate CSO-NGO partnership opportunities with USAID's Civil Society Strengthening Program (CSSP), implemented under a cooperative agreement by the NGO World Learning. The Contractor will determine with World Learning possible technical assistance needs from NGOs implementing health-sector funded small grants under the CSSP, and will coordinate the scheduling of technical assistance, with CTO approval.*

Task No. 3 Technical assistance to CSOs and NGOs on proven methods of IEC to access grants.

The Contractor must develop a “how-to” guide on proven IEC methods and messages specifically tailored to NGOs and CSOs. The guide will give a detailed approach on designing, costing, implementing, and evaluating health education lectures, radio programs, plays, and other materials and mechanisms that could be used at community levels to promote MCH/FP and RH. It shall focus on activities that can stand alone or be worked into non-health related activities such as agriculture, microenterprise, and private sector development. It will then serve as a primary training material to be used by the Contractor to assist the NGOs and CSOs in designing grant proposals that include or solely focus on IEC activities. The Contractor must also develop a grant evaluator’s checklist which will also be supplied to other USAID-funded projects to evaluate NGOs and CSOs that seek to tap into those projects’ grant mechanisms to fund IEC activities, **or coordinate in the development of one through USAID’s Civil Society Strengthening Program implemented by World Learning.** The Contractor must work with CSO umbrella organizations, such as Angolan Christian Council of Churches, Estrada N’Gola, and OMA as well as private sector companies to reach out to and encourage youth groups, women’s groups, and faith-based organizations to apply for such grants, and support them with training and TA. Funds should also be leveraged through the **business coalition** for community activities to generate demand, such as immunization awareness, family planning, male involvement, and youth health campaigns.

Task No. 4 Implementing Champion Community Initiative.

The Contractor must conduct workshops in each province for *Sobas*, representatives of local NGOs, CSOs, and public entities from all sectors to identify communities that are ready to take up the challenge of the Champion Community initiative. The Contractor must engage local leaders and community members to identify community issues, set goals, select indicators, and plan doable actions. The Contractor must identify one lead group from an NGO or CSO to monitor the implementation of the initiative in each community with monitoring tools developed by SES. The Contractor team shall help the committees evaluate their accomplishments, and see that once objectives are achieved, the community receives “Champion Status” in a public ceremony, and also look at ways to leverage awards sponsored by corporate partners.

e) Small Grants Management

The Contractor must manage a small amount of funds for grants to Angolan organizations and NGOs to support scale-up and replication of successful BCC and service delivery models. The Contractor must provide technical assistance in program design and grant management to organizations applying for grants under programs in health advocacy and government-community health partnerships. SES grants will be used to supplement such grants for targeted initiatives such as replication of community-health facility partnerships described in IR3; grants to women’s group such as ADEMA to distribute social marketing kits on safe motherhood to illiterate women at grassroots level or to Rede Mulher to conduct their health advocacy work (radio programs, newsletters, community meetings) in the targeted municipalities. **Additional grant funding may be available through USAID’s Civil Society Strengthening Program.**

f) Youth, Gender, Urbanization

The Contractor’s strategies shall focus on engaging women and youth in the activities as participants and beneficiaries. For example, The Contractor must train youth and widows as local community leaders; assist those facilities that provide youth-friendly maternal health services, help integrate adolescent RH services into school activities through Champion Community initiatives, and include techniques for analyzing gender disparities in relation to access to services in data analysis training. The Contractor must address the issue of

urbanization through prioritizing of geographic areas, focusing first on urban areas where pressure from the lack of quality services affects the greatest number of people, progressively rolling out activities into semi-urban and then rural areas.

g) Communications Plan

The Contractor must develop a communications plan, tied to the country communication strategy of USAID/Angola and shall include a reporting system designed to communicate project impact. The Contractor's team shall write success stories, case studies, and press releases and contribute to USAID's "Telling Our Story" website with a high standard for content and design and reflecting USAID branding guidelines.

h) Partnerships and Coordination

In 2006, ExxonMobil, and its local affiliate Esso Angola, gave alliance private sector funds to USAID Angola through the Gift Authority of the FAA to support the President's Malaria Initiative (PMI) program. A portion of these funds, \$500,000, were intended for building logistical and management capacity for malaria commodities, and to strengthen the Monitoring and Evaluation capacity within the Ministry of Health's National Malaria Control Program (NMCP). These alliance funds will be used to complement USG resources from the PMI program to make effective malaria medications available in as many health facilities as possible in its targeted areas. To this end, malaria funds will be used to carry out capacity building programs to complement these commodities and build management capacity in target municipalities and provinces. The technical assistance provided by USAID Global Health Bureau's Rational Pharmaceutical Management Plus (RPM+) Project in early October 2006 will be used to finalize a distribution plan for malaria commodities, which will form the basis of this work and the nature of this work and activities shall be defined in the annual work plan. Alliance private sector funds from Esso channeled by USAID to the Contractor must be used to match up to \$500,000 in FY07 PMI funds which are earmarked for building pharmaceutical management capacity in areas including, but not limited to, finalization of the distribution plan at a national and provincial level, development and printing of data forms, training of health staff, rehabilitation of storage facilities in the provinces, equipping of Provincial EDP offices and warehouses and improvement of M&E systems.

The capacity building work must be carried out in conjunction with NGOs that will be used as umbrella organizations in each province supported by PMI funds. These NGOs will be used to provide the "on the job" support to capacity building programs that will serve to instill new management and operational practices into the health workers, and will be expected to work with the contractor to build strong relevant collaborations in each province in which they work.

The Contractor must include in its workplan technical assistance and training activities for the PMI resources provided under this Task Order, including those funded with alliance private sector and USG funds, coordinating with USAID to ensure that it reinforces and complements technical assistance outputs generated from other sources. Approval of the anticipated results and activities will be accomplished through the contractor's annual work plan and detailed implementation plan.

ARTICLE 5. DELIVERABLES & REPORTS

In addition to the specific requirements for reports and other deliverables in the IQC and with reference to the Performance Management Plan (PMP) in this Task Order, the Contractor must

provide the following performance planning and monitoring reports to the USAID/Angola Cognizant Technical Officer. All reports must include gender sensitive SO- and IR-level indicators and numerical performance targets, task order-level benchmarks and milestones, and progress/performance-related data when the activity (ies) or its/their intended results involve or affect boys and girls or women and men differently and the difference is potentially significant for managing toward sustainable program impact.

a) Annual Work plan

- i) Within 45 days of the effective date of the task order, the Contractor shall submit electronically one copy of a draft first year work plan delineated by calendar quarters and covering one calendar year of the task order. The Work Plan shall include: 1) proposed activities for the period indicated; 2) inputs planned to be provided by the Contractor during the period; 3) outputs/outcomes which the Contractor expects to achieve, linked to the SO- and IR-level results; 4) baseline data; 5) numerical performance targets and the task order-level benchmarks, indicators and milestones; and the partners responsible for the planned activities, where appropriate. It shall be presented in a matrix or table format, with supporting narrative. Included shall be an explanation of how those task order-level outputs/outcomes are expected to achieve SO- and IR-level results and numerical performance targets. An estimated budget, identifying the anticipated inputs, shall be included.
- ii) The CTO shall review the draft annual work plan and shall provide comments within 30 days from receipt. Thereafter, the Contractor shall submit three copies of the final work plan within 15 days of receipt of the CTO's comments to the CTO for approval.
- iii) The Contractor shall submit draft annual work plans for subsequent years of the task order. The annual work plans must be submitted not later than December 1 of each year. The work plans shall include the same information with that of the first annual work plan.
- iv) All work plans, including significant revisions thereto, must be approved by the CTO. Should revised SO- and IR- level results or numerical performance or contract-level benchmarks and milestones become necessary, the Contractor shall submit a revised work plan covering the remaining period of the work plan year, following the procedures described above.
- v) The work plan will describe activities to be conducted at a greater level of detail than this task order's Statement of Work, but shall be cross-referenced with the applicable sections in the task order statement of work. All work plan activities must be within the scope of this Task Order. Work plan activities shall not change the task order statement of work or any other terms and conditions of this task order in any way. Changes may only be approved by the Contracting Officer, in advance and in writing. Thereafter, if there are inconsistencies between the work plan and the task order statement of Work or other terms and conditions of the task order, the latter will take precedence over the work plan.

b) Implementation Plan

The Contractor must submit a detailed implementation plan for the life of the project within 90 days after the effective date of the award and shall outline the timeline for phasing of

interventions. The Contractor shall propose benchmarks to reflect their “best guess” at major implementation thresholds during the course of the program that conform to the activities proposed. The Contractor will use the detailed implementation plan as a reference for subsequent annual workplans described above.

c) Monitoring and Evaluation Plan

The annual work plan needs a concrete and verifiable plan to monitor and evaluate the results, indicators and, deliverables for approval of USAID/Angola. The M&E plan shall be submitted as part of the annual work plan and within 45 days from the issuance of this task order. Indicators will be selected so as to minimize the costs and difficulties associated with monitoring and reporting. In order to aggregate results of all USAID programs worldwide so that global impacts can be reported to Congress and the American people, USAID/Washington has developed a set of Program Components into which all USAID-funded programs must fall. Each Program Component is associated with a set of Common Indicators which USAID Missions must report on as appropriate. The Contractor must track and report on Common Indicators relevant to this program. Program Components and Common Indicators can be found on USAID's website.

d) Quarterly Performance Monitoring Reports

The Contractor must submit quarterly progress reports to the CTO no later than 30 days after the end of each quarterly period. Progress reports shall include a clear, concise technical narrative, describing performance against an annual work plan and the M&E plan. These reports need to clearly identify deliverables and accomplished results, and measure impact in terms of the defined and approved performance indicators. With regard to performance indicators, the Contractor must include in the reports all the indicators agreed and approved for the program. The reports shall also highlight and fully discuss constraints and/or barriers to successful implementation, either on the part of the Contractor or host government, along with recommendations for problem resolution. The quarterly progress report shall also keep the CTO informed of any proposed changes in personnel.

e) Annual SO- and IR-Level Results Reports

The Contractor shall submit two copies of a draft annual SO- and IR-level results report, which shall describe progress using the SO- and IR-level results, approved performance indicators, success stories and numerical performance targets and covering the fiscal year ending on the previous September 30. This report shall also justify any under-achievement of targets and significant budget variations, discuss lessons learned, and recommend changes to the proposed program and work plan, if applicable. Grantee and subcontractor reports shall be included. The draft report shall be submitted to the CTO not later than October 15 and the CTO will provide comments within 15 days. The Contractor shall then submit two copies to the CTO for approval within 15 days of receipt of the CTO's comments. This report will be used for the Mission's annual report submission. An end-of task order final results report shall be submitted not later than the estimated completion date of the task order.

f) Final/Completion Task Order Report

The Contractor shall prepare and submit two copies of a final/completion report to the CTO which summarizes the accomplishments of this Task Order, methods of work used, and recommendations regarding unfinished work and/or program continuation. The final/completion report shall also contain an index of all reports and information products produced under this

Task Order. The report shall be submitted not later than 90 days after the estimated completion date of this Task Order.

The Contractor must prepare brief monthly reports to alert other members of the USAID Health Steering Committee of issues, potential problems, and progress, and to serve as a guide for discussions at Steering Committee meetings.

g) Monthly Financial Report

The Contractor shall submit a monthly financial report within 10 days after the end of each calendar monthly report period.

h) Property Reports

i) Non-expendable Personal Property

The Contractor shall submit/deliver two copies to the Contracting Officer of an annual property report containing the information required by the clauses of the basic IQC entitled, "Government Property (Cost-Reimbursement, Time-and-Materials, or Labor-Hour Contracts)" (FAR 52.245-05) and "Government Property – USAID Reporting Requirements" (AIDAR 752.245-70). The reporting periods are for each year of this Task Order. The report shall be submitted by the Contractor within 30 days from the end of the reporting period.

ii) Intellectual/Intangible Property - Invention and Patent Reports

The Contractor shall comply with the reporting and notification requirements of the clauses of the basic IQC entitled "Patent Rights – Retention by the Contractor (Short Form)" (FAR 52.227-11) and "Reporting Procedures" (AIDAR 752.227-70).

LANGUAGE REQUIREMENTS

The contractor's personnel and/or consultants shall have English and Portuguese language proficiency to perform technical services. Required reports and deliverables shall be prepared in English.

ANNEXES

The following annexes are hereby incorporated into this Task Order.

Acronyms
Results Framework (CORE SES PROGRAM)
Performance Management Plan

[END OF TASK ORDER NO. GHS-I-08-03-00025-00]

ACRONYMS

ABC	Abstinence, Be Faithful, and Use Condoms
ADEMA	Associação para Ajuda e Desenvolvimento da Mulher Angolana
AED	Academy for Educational Development
ARVs	Antiretrovirals
BC	Behavior change
BCC	Behavior change communication
BDM	Blood donor mobilization
CAs	Cooperating Agencies
CDC	Centers for Disease Control
CHVs	Community health volunteers
CIDA	Canadian International Development Agency
COP	Chief of party
ECD	Early child development
ENDIAMA	National Diamond Mining Company of Angola
FEWS NET	Famine Early Warning System Network
FHI	Family Health International
FP	Family planning
GRA	Government of Republic of Angola
HMIS	Health management information systems
HO	Home office
HSPH	Harvard School of Public Health
HIVAC	HIV/AIDS component of the Angola Essential Health Services/ Serviços Essenciais de Saúde (SES)
IDPs	Internally displaced persons
IEC	Information, education and communication
ITNs	Insecticide-treated nets
KRAs	Key results areas
LGA	Local government authority
M&E	Monitoring and evaluation
MCH	Maternal and child health
MIS	Management Information Systems
MOH	Ministry of Health
MOU	Memorandum of understanding
MSH	Management Sciences for Health
NGO	Nongovernmental organization
OMA	Organization of Angolan Women
PLWHA	People living with HIV/AIDS
PMP	Performance Management Plan
PMTCT	Prevention of Mother To Child Transmission (of HIV)
PPMD	Project Planning and Monitoring Department
PQI	Performance and Quality Improvement
PSI	Population Services International
QWEST	Quality, Workplace Environment & Safety Tool
RH	Reproductive health
SBM/R	Standards-Based Management and Recognition
SES	Essential Health Services/Serviços Essenciais de Saúde
SIP	Strategic intervention plan
SO	Strategic Objective
TBAs	Traditional birth attendants

TCN	Third-country national
TIPs	Trials for Improved Practices
TOT	Training of trainers
VAA	Value-Added Analysis
VCT	Voluntary counseling and treatment
VHC	Village Health Committees
WVI	World Vision International

RESULTS FRAMEWORK – CORE SES PROGRAM

PERFORMANCE MANAGEMENT PLAN