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EVALUATION

USAID/BENIN INTEGRATED FAMILY HEALTH PROGRAM & ACCELERATING THE REDUCTION OF MALARIA MORBIDITY AND MORTALITY PROJECT

March-April 2015

This publication was produced at the request of the United States Agency for International Development. It was prepared independently by Barbara Jones, Dr. Jaime Benavente and Dr. Moussa Couilbaly, consultants of the Global Health Program Cycle Improvement Project (GH Pro).

Cover Photo: A woman and child with their new mosquito net in Dangbo, Benin, which experiences large-scale flooding every rainy season. Long-lasting insecticide treated nets provided by the President's Malaria Initiative were provided to every family in the area.
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Evaluation Mechanism: Global Health Program Cycle Improvement Project (GH Pro), AID-
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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ACRONYMS

ACT	Artemisinin-based combination therapy
AMTSL	Active management of the third stage of labor
ANCRE	Advancing Newborn, Child and Reproductive Health
APC	Advancing Partners and Communities
ARM3	Accelerating the Reduction of Malaria Morbidity and Mortality
BCC	Behavior change communication
CAME	Central medical stores
CHW	Community health worker
DDS	Departmental Director of Health
DHS	Demographic and Health Survey
DSME	Maternal and Child Health Department
ETAT	Emergency triage assessment and treatment
FP	Family planning
G2G	Government-to-government
GHI	Global Health Initiative
HFG	Health Finance and Governance
HMIS	Health management information system
HSS	Health systems strengthening
iCCM	Integrated Community Case Management
IFHP	Integrated Family Health Program
IP	Implementing partner
IPTp	Intermittent preventive treatment in pregnancy
IR	Intermediate Result
IRSP	Institut Régional de Santé Publique
LDP	Leadership Development Program
LLIN	Long-lasting insecticide-treated nets
LMG	Leadership Management and Government
LMIS	Logistical Management Information System
MCH	Maternal and child health
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NMCP	National Malaria Control Program

NGO	Non-governmental organization
PAD	Program Appraisal Document
PIHI	<i>Paquet d'Interventions à Haut Impact</i> (Package of High Impact Interventions)
PISAF	<i>Projet Intégré de Santé Familiale</i>
PMI	President's Malaria Initiative
PSI	Population Services International
PSI/ABMS	Population Services International/Association Béninoise pour le Marketing Social
RAMU	<i>Régime d'Assurance Maladie Universelle</i> (National Health Insurance Program)
RDT	Rapid diagnostic test
RH	Reproductive health
RMIS	Routine Malaria Information System
SHOPS	Strengthening Health Outcomes through the Private Sector
SIFPO	Strengthening International Family Planning Organization
SOW	Statement of work
SP	Sulfadoxine-pyrimethamine
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND EVALUATION QUESTIONS

The purposes of this evaluation were to conduct a review of USAID/Benin's bilateral Integrated Family Health Program (IFHP) and to conduct a performance evaluation to date of the Accelerating the Reduction of Malaria Morbidity and Mortality (ARM3) project.

The USAID/Benin Health Team will use the IFHP review findings and recommendations to inform the design of the next bilateral health program. The ARM3 evaluation findings and recommendations will be used to set activity priorities for the remaining period of the project.

The statement of work (SOW) specified five evaluation questions:

- 1) What are the best practices and achievement of IFHP, including factors that have contributed to these successes?
- 2) What were the obstacles faced and limitations of IFHP, including factors that have contributed to these shortcomings?
- 3) To what extent has the ARM3 project contributed to the coverage and performance of malaria interventions in Benin?
- 4) In what ways did USAID/Benin's implementing partners (IP) collaborate with each other, the mission and other donor projects, and what collaborating opportunities were missed?
- 5) Based on evaluation findings, what are recommendations for the final year of the ARM3 and future (follow-on) program(s), with a focus on priority strategies and activities?

PROJECT BACKGROUND

USAID/Benin's IFHP, as described in the Program Appraisal Document (PAD), is focused on: (1) improving public health sector performance in delivering integrated family health services; (2) improving private health sector performance in delivering integrated family health services; and (3) improving preventive and care-seeking behaviors of an empowered population. IFHP also builds sustainability through health systems strengthening (HSS) and focuses on women, girls and gender equality. Multiple projects work under the IFHP and contribute to the strategic results framework, including:

ARM3, which was designed and awarded before the PAD, works closely with the National Malaria Control Program (NMCP) at the national level on policy issues and HSS. Activities to improve malaria prevention, diagnosis and treatment are implemented in 34 health zones throughout the country.

The Advancing Newborn, Child and Reproductive Health (ANCRE) project started in October 2014 and is focused on strengthening maternal-child health (MCH) and family planning (FP) services in the public and private sectors in support of the Ministry of Health (MOH) Package of High Impact Interventions (PIHI). ANCRE will also address HSS. Start-up of ANCRE in October 2014 ended a two-year gap since the end of the *Projet Intégré de Santé Familiale* (PISAF) in November 2012, the previous project that supported MCH-FP services.

Support to Community PIHI also started in October 2014 and is being implemented by multiple local non-governmental organizations (NGOs) that are receiving funding directly from USAID for the first time. The NGOs are managing the work of community health workers (CHW) that carry out PIHI activities at the community level.

Other projects working under IFHP include:

- Advancing Partners and Communities (APC) supports local NGOs implementing the Community PIHI activities.
- Health Finance and Governance (HFG) project works on the national health insurance plan and *mutuelles* and assists the MOH in preparing the National Health Account.
- Leadership, Management and Governance (LMG) project is building management capacity and leadership capabilities of the MOH.
- Africa Indoor Residual Spraying works on malaria vector control in the Atacora Department.
- Population Services International/Association Béninoise pour le Marketing Social (PSI/ABMS) supports social marketing and a social franchise of clinics.

The USAID/Benin development hypothesis is that universal access to essential health services identified in the MOH's PIHI, delivered by both the public and private sub- sectors and combined with improved preventive and care-seeking behavior by a more empowered populace will result in the improved health status of Beninese families, and that delivering these interventions under responsible government leadership and enabled local organizations will lead to more sustainable and scalable approaches and programs.

EVALUATION DESIGN, METHODS AND LIMITATIONS

The evaluation uses a mixed method approach and is based on a participative approach using both quantitative and qualitative methods. To estimate performance this evaluation relies on data collected by USAID and UNICEF such as the Demographic and Health Survey (DHS, 2012) and Multiple Indicator Cluster Survey (MICS, 2014), epidemiological information from the MOH and data collected by the evaluation team.

For site visits and data collection the evaluation team selected health zones in four departments where USAID supports activities. The selected zones are Tchaourou, Cove-Zagnanado-Ouinhi, Djougou-Ouake-Copargo and Bassila. Based on the total number of MOH health facilities in those zones, the team purposefully selected fifteen MOH facilities. Four ProFam clinics located in the same zones or departments were selected as suggested by PSI and two local NGOs working on Community PIHI were also selected for interviews.

Structured survey questionnaires were administered to a sample of clinical and managerial facility personnel and general health providers at 19 public and private health facilities in the health zones listed above. Semi-structured interviews were administered to officials of the central MOH; implementing partners; USAID-PMI; managers of local NGOs based in Tchaourou; Departmental Directors of Health (DDS) of Borgou/Alibori, Zou/Collines and Atacora/Donga; and health zone managers in Tchaourou, Cove-Zagnanado-Ouinhi, Djougou-Ouake-Copargo and Bassila. In addition, three focus group discussions were conducted with

clients present for services at facilities visited by the evaluation team. The survey was designed to include analysis at different levels (patient, facility and local health system level).

Evaluation Limitations and Challenges

1. This was an evaluation of two mechanisms, the bilateral program composed of multiple projects (IFHP), and a stand-alone project focused on malaria (ARM3). To answer the evaluation questions specified in the SOW, the evaluation team developed tools and methods of data collection to evaluate both IFHP and ARM3 at the same time. One member of the evaluation team particularly focused on malaria and ARM3.
2. A two-year gap between MCH-FP projects limited what the evaluation could assess in terms of IFHP contributions to integrated health services provided through the public and private sectors. As much as possible, the evaluation has cited support provided by USAID that may have contributed to quality improvements, increased access to and use of services and evidence-based decision making. Data collected on the current status of MCH-FP services are provided in order to make recommendations about priority activities and to identify gaps where remedial support is needed.
3. The time available for data collection limited the number of health zones and facilities the team could visit. Although originally planned for twelve days, the time frame for field data collection was reduced to five to ensure adequate time for meetings with USAID, MOH and IPs in Cotonou, and to obtain MOH approval to visit public health facilities.
4. The data collection plan was designed with the expectation of having access to the service statistics at the health facilities, which proved to be unrealistic. Record keeping is generally poor at the peripheral levels. The evaluation team used the structured interview guides to obtain estimated data from health personnel based on their experience, and as much as possible, checked facility records. Other data sources such as project reports, MOH annual statistics, and DHS data were used to cross-reference data obtained during site visits. However, the most recent MOH service statistics that are available are for the year 2013 and the most recent DHS data are from 2012.

KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

I. Finding: IFHP objectives have been partially achieved, primarily but not exclusively based on ARM3 achievements in malaria services and some improvement in supply chain management for malaria commodities.

- **Conclusion:** The two-year gap between USAID-funded projects with a focus on MCH-FP services has limited IFHP's achievements thus far in improving integrated family health services.
- **Conclusion:** Implementation of a new MCH-FP project is expected to provide support that will lead to improved quality and access to services and better integration of MCH-FP and malaria services.
 - **Recommendation:** To achieve integrated family health services, USAID/Benin and the IPs should work with the MOH to determine how to train and supervise health personnel to strengthen integrated service delivery. Rather than stand-alone training and supervision of malaria or antenatal care or FP, training and

supervision may need to be revised to emphasize service delivery that addresses multiple health needs in a single client visit.

2. Finding: The health management information system (HMIS) is cumbersome and does not provide reliable epidemiological data.

- **Conclusion:** Multiple reporting forms, programs and procedures are being used at the same time creating parallel systems that require additional effort and do not increase efficiency.
 - **Recommendation:** Specialized technical assistance is needed to revamp the HMIS. Rather than creating tools and programs that work for only one or two services, that are tailored for the reporting requirements of a donor or project, or that can't be used at the periphery, the MOH needs to develop a comprehensive HMIS that can facilitate effective planning, management and performance monitoring.
- **Conclusion:** Record-keeping and reporting of service statistics by many health facilities is unsatisfactory. Service statistics are not regularly recorded, consolidated and kept at a central point within the facility, which contributes to poor aggregation of data and accurate reporting from the facility to the zonal office.
 - **Recommendation:** Streamlined procedures, recording guidelines, reporting instruments and schedules should be developed.

3. Finding: Development of national guidelines for Community PIHI is an important step in standardizing the strategy, but there are critical issues that must be resolved for long-term sustainability and institutionalization.

- **Conclusion:** Critical issues in the Community PIHI strategy that will undermine the effort if not resolved include: sustainable sources of payment of the CHW monthly “motivation;” reliable mechanisms for providing CHWs with medications, commodities and supplies; improved skills of CHWs for supply management; effective collaboration of health zone and health center personnel and the CHWs.
 - **Recommendation:** ARM3, ANCRE, APC, local NGOs and the MOH must work together to find sustainable solutions and put them in place during the next six months.

4. Finding: Use of modern contraceptive methods remains low in Benin, and far below the 15 percent CPR objective of the Government of Benin and IFHP.

- **Conclusion:** Strategies to increase access to FP services are needed to increase use and reduce unmet need for FP.
 - **Recommendation:** Service delivery approaches such as mobile outreach should be implemented to augment FP services provided at health facilities in order to increase access in rural areas.
 - **Recommendation:** Training of health personnel is needed to ensure that skilled providers are available at all facilities. FP training should include dispensary

staff as well as maternity staff to foster more service integration and increase service availability.

- **Conclusion:** Shifts in method preference indicate increased need for trained providers and availability of methods and related expendable supplies.
 - **Recommendation:** Training of service providers for implant insertion and removal should be conducted to respond to increased demand for the method.
 - **Recommendation:** In addition to ensuring regular stocks of implants, supply chain management must include the related supplies needed for implant insertion/removal, e.g., betadine, gauze, bandages, sterile drapes, etc.

5. Finding: Many MOH facilities do not meet national standards for space, lighting, ventilation, staffing, equipment, etc.

- **Conclusion:** Physical conditions at many of the public health facilities visited are not conducive to the provision of quality services.
 - **Recommendation:** Facility assessments should be conducted in zones where USAID is supporting activities to determine if a facility meets the minimal standards for quality services. These data can then be shared with the facility and the district health offices to develop plans for quality improvement.
 - **Recommendation:** Based on the facility assessment, plans and specification should be developed for facility upgrades and procurement of equipment and instruments to improve the quality of PIHI services.

6. Finding: Malaria remains the leading cause of morbidity despite large investments in prevention, diagnosis and treatment.

- **Conclusion:** Continued scale-up and strengthening of diagnosis and treatment are essential, but additional attention is needed to prevent malaria and reduce the burden of disease.
 - **Recommendation:** The intermittent preventive treatment in pregnancy (IPTp) indicator for ARM3 and IFHP should be updated to reflect the revised policy of giving three doses of sulfadoxine-pyrimethamine (SP) to all pregnant women.
 - **Recommendation:** Although pregnant women and young children are particularly vulnerable to malaria, malaria also causes decreased productivity among adults and school-aged children. Promotion of consistent use of long-lasting insecticide-treated nets (LLINs) by everyone is needed as one element of vector control.
 - **Recommendation:** ARM3 should work with the President's Malaria Initiative (PMI) and the NMCP to identify effective vector control strategies that can be implemented in Malanville and Parakou, where there is high risk of malaria transmission and almost continuous exposure due to rice cultivation and vegetable farming. This recommendation is not intended to suggest that ARM3 should implement new vector control strategies, but rather to investigate

potentially effective strategies that could be tested and implemented during a follow-on project if there is one.

7. Finding: Inclusion of literacy as a criterion for CHW selection may result in fewer women being selected as CHWs.

- **Conclusion:** Since women are less likely than men to be literate, particularly in rural areas, the literacy requirement may result in a gender imbalance among male and female CHWs that provide the complete PIHI package.
 - **Recommendation:** The literacy criteria should be re-examined in order to find ways to accommodate women who have low literacy skills. Using them as PIHI “promoters,” who are not eligible for the monthly motivation payment, is not an adequate alternative.

8. Finding: Coordination and collaboration among USAID projects and between projects and the MOH, particularly at department and zonal levels, needs to be improved.

- **Conclusion:** With new USAID-supported projects starting to implement activities, this is an opportune time for the IPs to improve communication and collaboration with department and zonal authorities.
 - **Recommendation:** At department/zonal levels, IPs should offer to play a secretariat function, if needed, to assist the DDS or Zonal Coordinator in conducting quarterly coordination meetings with the IPs supporting activities in the area.

I. INTRODUCTION

EVALUATION PURPOSE

At the request of USAID/Benin, the Global Health Program Cycle Improvement Project (GH Pro) organized a team to conduct a performance evaluation of the mission's bilateral Integrated Family Health Program (IFHP), which includes projects to strengthen the health system and improve services for malaria, family planning (FP) and maternal and child health (MCH).

The evaluation statement of work (SOW) indicated a mid-term performance evaluation of IFHP and an end-line evaluation of the ARM3 project. During the initial briefing in-country and a follow-up meeting, the USAID/Benin Health Team clarified that the evaluation was intended to provide:

- An overall review of the IFHP
- A performance evaluation **to date** of the ARM3 project.

The USAID/Benin Health Team will use the IFHP review findings and recommendations to inform the design of the next bilateral health program. The mission is interested in identifying an appropriate mix of projects that maximizes effectiveness and efficiency and supports a fully integrated health program. As such, the review focused on assessing achievements and the current situation in selected coverage areas, implementation challenges, lessons learned and programmatic gaps.

The ARM3 evaluation findings and recommendations will be used by PMI (USAID and CDC), the ARM3 partners and the National Malaria Control Program (NMCP) to set activity priorities for the remaining period of the project in order to maximize results.

USAID/Benin, implementing partners and the Government of Benin are the primary audience for the evaluation.

EVALUATION QUESTIONS

The SOW specified the following five evaluation questions. The questions and additional explanations and details can be found in Annex I.

- 1) What are the best practices and achievement of IFHP, including factors that have contributed to these successes?
- 2) What were the obstacles faced and limitations of IFHP, including factors that have contributed to these shortcomings?
- 3) To what extent has the ARM3 project contributed to the coverage and performance of malaria interventions in Benin?
- 4) In what ways did USAID/Benin's implementing partners (IP) collaborate with each other, the mission and other donor projects, and what collaborating opportunities were missed?
- 5) Based on evaluation findings, what are recommendations for the final year of the ARM3 and future (follow-on) program(s), with a focus on priority strategies and activities?

The SOW specified that evaluation should consider the following program elements:

- Malaria (PMI/ARM3)
- Package of High Impact Interventions (PIHI)
- Public sector health system strengthening based on six health system building blocks¹
- Private sector quality of services
- Gender
- USAID/Benin's IFHP PAD modifications during the life of the project

¹ WHO defines health system building blocks as: service delivery, health workforce, health information system, access to essential medicines, financing, and leadership and governance.

II. PROJECT BACKGROUND

In 2010, the Government of Benin/Ministry of Health (MOH) adopted a new strategy, the Package of High Impact Interventions (referred to by the French acronym *PIHI*), in order to focus national efforts on achievement of the Millennium Development Goals 4 and 5 for maternal and child health. USAID and other donors committed to supporting the MOH in strengthening and scaling-up PIHI at facility and community levels.

USAID/Benin's bilateral health program, known as the IFHP is based on the Global Health Initiative (GHI) country strategy and supports the PIHI strategy. IFHP has three result areas: (1) improving public health sector performance in delivering integrated family health services; (2) improving private health sector performance in delivering integrated family health services; and (3) improving preventive and care-seeking behaviors of an empowered population. IFHP also addresses building sustainability through health systems strengthening (HSS) and focuses on women, girls and gender equality.

Since its initial approval in October 2012, the IFHP Program Appraisal Document (PAD) has been modified twice: In April 2013, a component for adolescent sexual and reproductive health was added, and in August 2014, revisions were made in plans for government-to-government funding. According to the evaluation SOW, these modifications delayed the mission's funding obligations for a new bilateral MCH/FP project and mechanisms to support community PIHI. Each modification also resulted in adjustments to the timeline and awards under the PAD due to changes in the budget and program priorities; however, the results framework did not change. (See Annex IV.)

Through the projects working under IFHP, USAID supports multiple departments and programs of the national level of the MOH and supports implementation of activities in priority health zones. A map of Benin is included in Annex V for reference.

The PMI-funded bilateral project, ARM3, was designed and awarded one year before the PAD and works closely with the NMCP at the national level on policy issues and HSS. Activities to improve malaria prevention, diagnosis and treatment are implemented in all 34 health zones of the country.

The Advancing Newborn, Child and Reproductive Health (ANCRE) project and Support to Community PIHI were awarded in October 2014 and are the mission's other major health projects. ANCRE is focused on improving MCH and FP services provided by the public and private sectors and HSS. Support for Community PIHI is being implemented by local non-governmental organizations (NGOs) that are receiving funding directly from USAID for the first time. The NGOs will support scale-up of community PIHI activities carried out by community health workers (CHW).

Other projects working under IFHP include:

- Advancing Partners and Communities (APC) provides technical assistance to local NGOs that receive funding directly from USAID/Benin to implement the Community PIHI activities.

- The Health Finance and Governance (HFG) project is working to strengthen the national health insurance plan and develop community-based health insurance organizations, or *mutuelles*, and their national umbrella organization. HFG also provides assistance to the MOH for preparation of the National Health Account.
- The Leadership, Management and Governance (LMG) project is focused on building management capacity and leadership capabilities within divisions of the national MOH and selected departments.
- Africa Indoor Residual Spraying conducts periodic campaigns to spray houses to control mosquitos and prevent malaria transmission.
- PSI/ABMS supports social marketing activities for family health products such as Orasel/Zinc and Aquatabs, and methods for contraception and prevention of HIV and sexually transmitted infections. PSI/ABMS also supports a social franchise of more than 50 private clinics, branded as “ProFam,” that offer a range of health services depending on capacity of the clinic personnel, availability of equipment and infrastructure.

III. EVALUATION METHODS & LIMITATIONS

EVALUATION METHODS AND LIMITATIONS

The USAID/Benin development hypothesis is that universal access to essential health services identified in the PIHI, delivered by both the public and private sectors and combined with improved preventive and care-seeking behavior by a more empowered populace, will result in the improved health status of Beninese families and that delivering these interventions under responsible government leadership and enabled local organizations will lead to more sustainable and scalable approaches and programs.

Evaluation Approach

The evaluation follows the USAID 2011 Evaluation Policy aimed at improving accountability, learning and evidence-based decision-making. USAID's Health Sector Development Objective, Intermediate Results (IRs) and Sub-IRs and indicators are the framework upon which this evaluation is defined. The evaluation uses a mixed-method approach. The study design relies on the baseline data collected by USAID and other stakeholders to measure the contribution of the U.S. Government to improve the health status of the Beninese families at national and sub-national levels.

The evaluation is based on a participatory approach using both quantitative and qualitative methods. Thus, the evaluation collected, analyzed and interpreted quantitative and qualitative data in order to answer the evaluation questions. The methods consist of document review, semi-structured interviews with key informants recorded according to a guide, focus group discussions using a question guide and structured interviews with health facility personnel. Combining results from structured and semi-structured interviews and focus groups allowed the evaluation team to assess the opinions of those responsible for the implementation of the projects and to consider the perspectives of beneficiaries of services.

Quantitative Approach

Descriptive statistics and other non-parametric quantitative approaches assisted in identifying relationships and potential effects. A major challenge of a performance evaluation is to compare the status of the beneficiaries before and after the intervention in a manner that accounts for the effect of other factors external to the program. One way to approach this problem is to have access to high-quality baseline measurements that can provide statistical grounds for correct comparisons of the level of some key variables between t_0 (prior the beginning of interventions) and t_1 (the point of evaluation). In this case, the DHS was used as baseline (t_0).

Structured survey questionnaires were administered to a sample of clinical and managerial facility personnel and general health providers at 19 health facilities in the health zones of Tchaourou; Cove-Zagnanado-Ouinhi; Djougou-Ouake-Copargo; and Bassila. The quantitative indicators are derived from the analysis of statistical data available to the evaluation team and from reviewing records when visiting sites.

Qualitative methods

The team used qualitative methods to add depth to the quantitative measures of performance changes. These techniques included semi-structured interviews administered to managers of local NGOs; officials in charge of the central MOH; Departmental Directors of Health (DDS)

for Borgou/Alibori, Zou/Collines and Atacora/Donga; and health zone managers in the selected zones visited by the evaluation team. Semi-structured interviews were also conducted with IPs and donors. Focus group discussions were conducted to identify psychosocial issues and concerns of the beneficiary population. The team held discussions with three focus groups consisting of six to 12 participants getting services at a facility included in the sample.

For the ARM3 evaluation, the activities included an assessment of case management, a qualitative analysis of program implementation from October 2011 to December 2014 and a qualitative data analysis of users and beneficiaries.

Secondary Sources

The secondary sources included databases from governmental entities, project records, USAID, other donors and partners, as well as local information on health conditions, health interventions and service coverage.

Sample Design and Fieldwork

Two steps were followed in the sampling process:

1. Agreement on the sample frame: The first step was to define and obtain USAID agreement on a sample of health facilities. The evaluation team met with members of the USAID Health Team who put together the chart below to begin the selection process.

Table 1. Sampling Considerations

Health Zone	Department	Presence of former integrated family health project	Existing Community PIHI work for more than 2 years	Mhealth (community)	ANCRE (PIHI start-up)	ARM3 (Malaria, RMIS, SCM)	Option see Profam Clinic(s)	Accessibility
1) Tchaourou	Bourgou/Alibori	No	Yes	Yes	Yes	Yes	Yes-Parakou	Easy access, district before Parakou
2) Cove/Zagnanado/Ouinhi	Zou/Collines	Yes	No	No	Yes	Yes	Yes-Abomey Bohicon	Easy access 2-3 hours from Cotonou on main road to North, accommodations in Bohicon
3) Kandi/Gogounou/Segbana	Bourgou/Alibori	No	Yes	No	Yes	Yes	Yes-Parakou	Far North, hours north of Parakou
4) Djougou/Ouake/Copargo	Donga	No	Yes	No	Yes	Yes	Yes, Savalou on the way	Deteriorated road from Savalou to Djougou, about 4 hours north of Bohicon
5) Bassila	Donga	No	Yes	Yes	Yes	Yes	Yes, Savalou on the way	Deteriorated road from Savalou to Basila, accommodations in Djougou, about 4 hours north of Bohicon
6) Allada/Ze/Toffo	Atlantique	Yes	Yes	Yes	Yes	Yes		Difficult to access, centrally funded community work

After considering distance, road conditions and travel time, USAID and the evaluation team eliminated health zones in the third and sixth rows of the chart. The universe of this evaluation was the total number of MOH facilities in the remaining health zones and related departments on the chart where USAID supports health interventions, i.e., Tchaourou, Cove-Zagnanado-Quinhi, Djougou-Ouake-Copargo and Bassila.

The department-specific data was aggregated to draw some conclusions, while the zone sub-sample confirmed the evaluation final sample. Facilities presenting extreme logistical or other barriers were excluded from the final selection after consultation with USAID.

2. Construction of the sample: The second step in the construction of the sample was the selection of facilities to be visited. Using the list of all MOH health facilities (96) in the selected zones as the sampling frame, 15 public health facilities were purposefully selected, including zonal hospitals² and health centers (types I and II³). Four private ProFam clinics were purposefully selected with PSI, and two local NGOs (Dedras and Sian'son) working on Community PIHI were conveniently selected.

Data Collection and Instruments

Data collection covered the period from February to March 2015. The evaluation team split into two sub-teams for the fieldwork and data collection. Data was collected in each site by a team of three data collectors (including at least one person familiar with the provision of health services). Overall, there were six interviewers, including the two supervisors. On average, data collection was conducted at a rate of one to three sites per day. A precise visit plan was developed to facilitate data collection. A total of six instruments (questionnaires and detailed protocols) for data collection were prepared, as shown in the table below. These instruments were administered to gather data for determining the performance of both IFHP and ARM3. (See Annex III).

Table 2. Data Collection Instruments

Instruments	Subjects
1. Facility questionnaire	Clinical, service and managerial personnel
2. Focus group discussion guide for clients	Patients attending the facility that day
3. Semi-structured interview: Questions for NGOs	Director, manager, senior staff
4. Semi-structured interview: Questions for central MOH, DDS and zones	Officials of MOH, DDS and zones
5. Semi-structured interview: Questions for IPs, USAID, PMI	Representatives of IPs, USAID and PMI
6. Questions for donors	Donor representatives

The site assessment instruments were applied to relevant staff coordinating activities in the health units. Data collectors entered data into a customized database created for the evaluation at the end of each day.

² Usually there are 1 or 2 hospitals per zone.

³ Health center “type I” has a physician on staff; “type II” does not have a physician.

The following table depicts the final sample of health facilities that were visited by the evaluation teams to collect the required data for the evaluation.

Table 3. Number of Health Facilities Planned and Completed According to Sample Design by Level of Service

Level	Donga and Collines			Zou and Borgou			Total		
	Planned	Complete	Incomplete	Planned	Complete	Incomplete	Planned	Complete	Incomplete
Zone Hosp	1	1		2	2	0	3	3	0
Hlth Ctr 1	2	2		3	3	0	5	5	0
Hlth Ctr 2	5	5		2	2	0	7	7	
Private Clinic	1	0	1	3	0	3	4	0	4
Total	9	8	1	10	7	3	19	15	4

Of the total number (19) of health facilities sampled, 15 (79 percent) interviews/questionnaires were totally completed and four were partially completed. Incomplete visits were due to unforeseen circumstances and several questionnaires were not fully completed.

Training and Supervision

Selected facilities were randomly selected for phone validation for a number of questions and rechecking specified data items. Fieldwork was supervised and monitored during the pre-test and initial data collection in one of the four departments.

Data Management

Assessment tools were registered and entered into a database. Double data entry was used to check the quality and consistency of entries. In addition, external validation of the data collection and quality of data was carried out.

Data Analysis Plan

The evaluation team developed a comprehensive analysis plan. The survey was designed to include analysis at different levels (patient, facility and local health system). Data analysis also focused on comparisons between results from this evaluation and those from other similar surveys.

Evaluation Limitations and Challenges

1. This was an evaluation of two mechanisms, the bilateral program composed of multiple projects (IFHP), and a stand-alone project focused on malaria (ARM3). To answer the evaluation questions specified in the SOW, the evaluation team developed comprehensive tools and methods of data collection to evaluate both IFHP and ARM3 at the same time. One member of the evaluation team particularly focused on malaria and ARM3.

2. A two-year gap between MCH-FP projects limited what the evaluation could assess in terms of USAID contributions to integrated health services provided through the public and private sectors. As much as possible, the evaluation report has cited support provided by USAID that may have contributed to quality improvements, increased access to and use of services and

evidence-based decision making. Data collected on the current status of MCH-FP services is provided in order to make recommendations about priority activities and to identify gaps where remedial support is needed.

3. The time available for data collection limited the number of health zones and facilities the team could visit. Although originally planned for twelve days, the time frame for field data collection was reduced to five days to ensure adequate time for meetings with USAID, MOH and IPs in Cotonou, and to obtain MOH approval to visit public health facilities.

4. Due to the short notice between MOH approval to visit health facilities and travel to the field sites, official notice of the evaluation team's visit was not received by all department and zonal authorities that the team expected to meet. In several cases, the evaluation team was unable to meet with the DDS or Zonal Coordinator because of scheduling conflicts but was able to meet with another senior manager to collect the needed information.

5. The data collection plan was designed with the expectation of having access to the service statistics at the health facilities, which proved to be unrealistic. Record keeping is generally poor at the peripheral levels. The evaluation team used structured interview guides to obtain estimated data from health personnel based on their experience and, as much as possible, checked facility records. Other data sources such as project reports, MOH annual statistics and DHS data were used to cross-reference data obtained during site visits.

IV. FINDINGS

The findings presented in this report are based on data collected and analyzed as described in the methodology section above. They are organized according to the five evaluation questions from the SOW. Findings about the provision and quality of health services are based on data collected from a limited sample of health facilities and do not reflect the situation in Benin as a whole.

I. WHAT ARE THE BEST PRACTICES AND ACHIEVEMENTS OF THE IFHP, INCLUDING FACTORS THAT HAVE CONTRIBUTED TO THESE SUCCESSES?

In 2010, the Government of Benin adopted a Package of High Impact Interventions (referred to by the French acronym *PIHI*) in order to better focus national efforts on achievement of the Millennium Development Goals 4 and 5 for MCH. USAID and other donors committed to supporting the MOH in strengthening and scaling-up PIHI. At that time, USAID's bilateral health project, PISAF, revised its activities to improve malaria, MCH and FP services through implementation of PIHI.

The malaria-focused ARM3 project started in 2011, one year before the start of the IFHP. The project has scaled up malaria interventions started by PISAF and initiated new activities to support malaria prevention and improved diagnosis and treatment. (See Q3 for more information about ARM3.)

When PISAF ended in November 2012, USAID expected to continue MCH and FP support with the award of a follow-on project focused on improving integrated family health services provided by the public and private sectors, i.e., IR1 and IR2 of the Strategic Results Framework. (See Annex IV.) Delays in the design and approval of the follow-on project resulted in a two-year gap between the end of PISAF and the start-up of ANCRE in October 2014.

Without a USAID-funded project focused on MCH and FP for the first two years of the IFHP, achievements in the health sector are primarily related to malaria and health systems strengthening. As the ANCRE project starts to implement activities in the health zones, achievements in a broader range of family health services are expected. Despite the absence of a project to support public sector MCH-FP service delivery, USAID/Benin has continued to support the MOH's PIHI strategy through other projects and technical assistance for policy development, capacity building and health systems strengthening.

Findings related to improvements in the provision of health services and functioning of the health system that have benefitted from USAID support are described below.

IFHP achievements

At the time of this evaluation (March-April 2015), achievements of IFHP are primarily related to malaria and some aspects of HSS. Many IFHP objectives for MCH, FP and HSS are predicated on technical and financial support to be provided by the ANCRE project, which did not start until October 2014. Therefore, the limited achievements in MCH and FP services are due to the two year gap between USAID-funded projects focused on MCH-FP, which has affected all the IFHP IRs.

IR 1: Improved public health sector performance in delivering integrated family health services

As stated in the PAD, this IR is intended to “strengthen the health system and expand coverage of quality, integrated high impact services offered through the PIHI package, increasing financial access with universal health insurance and strengthening the supply chain for health commodities.”

Sub-result 1.1: Improved planning and management of health systems and services, especially at decentralized level

To support improvements in planning and management capabilities and provide direct funding to central MOH departments and programs, the LMG project worked with the Institut Régional de Santé Publique (IRSP) to develop and conduct management training courses to include managing US government funds. Consistent with USAID Forward, the PAD specified that government-to-government (G2G) agreements are to be made with the MOH, including the Maternal and Child Health Department (DSME), Expanded Immunizations Program, the NMCP, the Finance and Resource Management Department, the Planning and Prospective Department and the Central Medical Stores (CAME). As yet, those G2G agreements with MOH units have not been established. However, USAID has established direct funding agreements with IRSP to conduct epidemiological sentinel surveillance, with the Centre de Recherche Entomologique de Cotonou for entomological surveillance and with local NGOs for management of community PIHI implementation.

The LMG project also introduced the Leadership Development Program (LDP) with several MOH departments, the DDS of Mono/Couffo, the Klouékamé health zone and the Maternal-Child Hospital of Lagune (HOMEL). LDP is conducted over a period of six to eight months to improve teamwork and establish a process of performance improvement. The LMG staff told the evaluation team that the HOMEL director has found the LDP approach helpful and has continued to use the process after the initial six-month period. The evaluation team does not have other information about the effectiveness of LDP.

Benin uses a fee-for-service system for health care in both the public and private sectors. To reduce the financial barrier to service access, the Government of Benin has developed a national health insurance program, *Regime d'Assurance Maladie Universelle (RAMU)*. The HFG project has provided technical assistance for development and roll-out of RAMU, which is now open for enrollment in 14 of the country's 34 health zones.

The IFHP PAD states that technical assistance will be provided to the MOH to “improve the availability and use of timely and complete health information statistics from the service delivery level.” There have been some improvements in the health management information system (HMIS), although the improvements are primarily related to malaria information as a result of support provided by ARM3.

The analysis of the HMIS in Benin shows a “system” that: (1) does not work at the primary source of information (service delivery); (2) does not function under the same parameters at every level; (3) transmits unverified data from a source level to a superior level; (4) does not provide feedback from superior levels to lower levels; (5) does not support data collection with

appropriate materials and tools; and (6) does not have corrective mechanisms to solve the problems in data production. In summary, it is not a system.

MOH managers and facility personnel interviewed said the national HMIS is cumbersome and requires about 12 different report forms to be completed and submitted. Delays in data submission along the reporting chain, i.e., from health center to zone to department to the national level, are frequent.

Use of a stand-alone information system, the national Routine Malaria Information System (RMIS) has improved the availability of malaria data that are used for tracking and assessing malaria indicators. However, the RMIS adds another layer of data entry and reporting and may not be compatible with other data reporting requirements, and it contributes to the plethora of parallel systems being used by different programs and projects.

At the health center and zonal hospital levels, data entry is manual due to lack of trained staff and computer equipment. At the peripheral level, lack of electricity and internet service hinder the feasibility and utility of computerized systems.

Most department and zonal managers interviewed said the HMIS does not include service statistics from CHWs for community PIH or private sector providers, including ProFam clinics. Without such data, the effectiveness of the community PIH strategy cannot be determined and problems cannot be addressed. Likewise, lack of data from the private sector limits the MOH's ability to accurately assess total service coverage. The MOH's Annual Service Statistics reports for 2011, 2012 and 2013 show no data for PSI as a source of FP services by department, whether through social marketing outlets or the ProFam clinics.⁴ ProFam has its own information system that clinic managers use to submit service reports to PSI/ABMS.

Some of the data management problems inherent in the current HMIS might be ameliorated with a new system (DHIS2) that is being developed. The current HMIS is based on Microsoft Access, which has a limited number of fields that can be incorporated. Because the maximum number of fields has been reached, the HMIS cannot include even the most basic community-level data, such as the number of malaria cases treated. The DHIS2 is based on open source software and can incorporate multiple sub-reporting systems.

An early success of the ANCRE project has been the development of harmonized national guidelines for community health monitoring and evaluation that were validated in January 2015. Having achieved national consensus, it is likely that the community-level M&E indicators will be incorporated in the DHIS2.

Although the DHIS2 might allow better data management, using data for planning and program decision-making is also needed. Managers at all levels reported that there is virtually no feedback about HMIS reports from central and department levels to zonal and peripheral levels and little, if any, analysis of reports within facilities to assess problems and identify trends.

As of May 2015, the most recent MOH report of annual service statistics that was available was for 2013.

⁴Ministère de la Santé. Annuaire des Statistiques Sanitaires, 2011, 2012, 2013.

Sub-result 1.2: Improved quality service delivery, especially for women and young children, at health facilities

Since the start of IFHP, USAID has supported scale-up of service delivery aspects of the PIHI strategy primarily through the ARM3 project. USAID support has contributed to development and revision of national policies and guidelines; training of public sector health providers in malaria prevention, diagnosis and treatment; strengthening of supervision approaches; development of job aids; and procurement of equipment, commodities and supplies.

ARM3 has supported training of health personnel in intermittent preventive treatment in pregnancy (IPTp) using sulfadoxine-pyrimethamine (SP). Data in ARM3 reports show that as of 2014, 45 percent of ANC clients received two doses of SP, up from 28 percent in 2011 when the project started. That represents a large increase, although it falls well short of the PAD objective of 85 percent.

At sites visited by the evaluation team, health personnel reported that 67 percent of ANC clients received at least two IPT doses of SP. The evaluation team does not have specific information about the large discrepancy in reported percentages from ARM3 and the health providers interviewed, but several explanations can be suggested: (1) ARM3 data are national versus the small sample of facilities visited by the evaluation team where there may be more trained providers and the facilities have fewer stock-outs of SP; and (2) more facilities sampled by the evaluation may be included in performance-based financing activities that encourage improved performance. (Performance-based financing was not taken into consideration when developing the evaluation sample of facilities, nor was it an issue for which the evaluation team collected data.)

USAID and ARM3 advocated with the MOH/NMCP to adopt the WHO IPTp recommendation of using three doses of SP for all pregnant women rather than two. NMCP revised the policy in January 2015, and ARM3 supported training for more than 1,000 health workers in the new policy. However, many providers interviewed by the evaluation team were not aware of the policy change and are still following the old policy of giving three doses of SP only to women who are HIV-positive.

Regarding improved diagnosis and treatment of malaria, the ARM3 project reports for 2014 show that 82 percent of patients (all ages) who tested positive for malaria (using microscopy or rapid diagnostic test (RDT)) were treated with artemisinin-based combination therapy (ACT). This result is very close to the PAD objective of 85 percent.

With assistance from ARM3 the Emergency Triage, Assessment and Treatment (ETAT) protocol has been scaled up nationwide and is used in approximately 90 percent of all hospitals both public and private. Adherence to the ETAT protocol is associated with a reduction in the case fatality rate from severe malaria: Over a six-month period from April to October 2014, the case fatality rate declined by 48 percent (from 6.6 to 3.4) in 12 hospitals using ETAT. The PAD objective is a 30 percent reduction in mortality due to severe malaria among children at public hospitals.

Other elements of integrated family services, i.e. maternal health and FP, have not had the benefit of a USAID-supported project to reinforce improvements made by the PISAF project that ended in November 2012, and they are far below the IFHP PAD objectives. For example,

the PAD calls for “at least 80 percent of health zones appropriately equipped and staffed to provide essential obstetric and newborn care.” At the public health centers visited by the evaluation team, basic emergency obstetric and newborn care (EmOC) is not available, due to lack of trained staff and equipment. Complete EmOC is available at two of the three zonal hospitals visited. The zonal hospital at Tchaourou does not have equipment or personnel with the requisite knowledge and skills. Of all the health facilities (MOH and ProFam) visited by the evaluation team, 56 percent of the delivery rooms do not meet national norms for space, light, ventilation, equipment and cleanliness.

The IFHP PAD objective for modern contraceptive prevalence is 15 percent, which is consistent with the MOH objective. Despite the significant contributions by USAID and UNFPA that fund and procure most contraceptive commodities for Benin, use of modern methods of contraception in Benin remains low. CPR has shown a gradual increase from seven percent in 2006 to nine percent in 2012 according to the Demographic and Health Surveys (DHS).^{5 6} Unmet demand for family planning is 32.6 percent according to the 2012 DHS.

Although USAID has not had a project to support public sector FP service delivery activities for two years, the PISAF project trained health personnel and the ANCRE project will support activities to improve quality and availability of FP services in the near future. Several key informants, including the deputy director of the Division of Maternal and Child Health at the national MOH and the chief of MCH/FP at the Department of Health for Borgou/Alibori, said that family planning is a priority and they are eager for the ANCRE to provide assistance to train newly hired health personnel in family planning and other MCH services.

Health personnel interviewed reported that all reversible FP methods, both short- and long-acting, are offered at peripheral public health facilities if there is a trained provider on the staff. Although contraceptives might be available in a given facility, staff shortages and transfers of trained staff result in FP services not being available. Other than CHWs that conduct community-based distribution of condoms and pills, FP services are provided at health facilities; mobile outreach services to increase access to long-acting methods for women living in remote areas are not conducted.

The nurse in-charge of the dispensary unit at a health center visited by the evaluation team said that FP services are offered in the maternity unit, where the midwives have been trained in FP. If the midwives are occupied with ANC consultations or deliveries, FP clients have to wait or be referred to another facility, because dispensary staff have not been trained in FP.

The MOH Annual Service Statistics reports for 2011 and 2013 indicate shifts in method preference that suggest a need for additional training of providers and verification that expendable supplies needed for implant insertion and removal, e.g., betadine, gauze, bandages and sterile drapes, are available through the supply chain.

⁵ Institut National de la Statistique et de l'Analyse Économique (INSAE) [Bénin] et Macro International Inc. 2007. *Enquête Démographique et de Santé, Bénin 2006: Rapport de synthèse*. Calverton, Maryland, USA: INSAE et Macro International Inc.

⁶ Institut National de la Statistique et de l'Analyse Économique (INSAE) et ICF International. 2013. *Enquête Démographique et de Santé du Bénin 2011-2012 : Rapport de synthèse*. Calverton, Maryland, USA: INSAE et ICF International.

Table 4. Method Preference

Method	Percentage of Modern Method Users	
	2011	2013
Pill	60.3	19.7
Injectable	24.1	37.1
Implant	9.5	31.5
IUD	6.2	11.5

(Additional information on the general status of MCH and FP services reported to the evaluation team is included in Annex VI for reference. Given the two-year gap between the PISAF and ANCRE projects, information about MCH-FP services at sites visited does not reflect recent USAID support but might be useful for future activity planning.)

Despite support by ARM3 and other projects for staff training and capacity building, the lack of adequate numbers of staff at MOH facilities is a limiting factor in service quality improvement. None of the public facilities visited by the evaluation team have the number of staff specified in the MOH standards, and few have the number of staff specified by professional category. Personnel at several facilities said that staff shortages make it difficult to ensure 24/7 emergency coverage. (See Annex VII for a table of facility staff by category.)

Sub-result 1.3: Essential commodities more available at service and product delivery points

Most health personnel interviewed by the evaluation team reported that the supply chain system works better than it did two to three years ago, although stock-outs of essential commodities still occur.

MEDISTOCK, a software program for stock management, was initially introduced by PISAF; its application and scale-up is supported by ARM3. MEDISTOCK currently incorporates only malaria supplies and commodities and is used by CAME (the central medical store) and at the department level, where there are appropriate computers and trained staff. Supply management staff at the zonal hospitals visited have been trained to use MEDISTOCK, although at the health zone in Cové the manager has never used the program because there is no computer.

The capacity of staff with responsibilities for supply management is generally weak. At the Health Center I facilities visited, 50 percent of staff in charge of supplies have been trained; at the Health Center IIs visited, no staff reported being trained in supply management.

In the three months prior to the evaluation, health personnel at MOH facilities reported having stock-outs of RDTs (11 percent), all formulations of ACTs (33 percent) and antibiotics (59 percent), which indicates that supply management problems persist.

Staff at MOH facilities in Borgou, Zou and Donga reported having a surplus of insecticide-treated mosquito nets: health personnel said they had been instructed not to distribute them because nets had been widely distributed by the Africare PILP project.

In the event of stock-outs of medicines and supplies, health personnel reported various ways of responding: do nothing and wait for new supplies, give clients a prescription and send them to a

private pharmacy, and refer clients to the closest health facility. A few said they contact the zonal distribution warehouse to obtain medicines to hold them over until their new shipment arrives.

IR 2: Improved private health sector performance in delivering integrated family health services.

This IR is intended to improve the quality of health services provided by the private sector, including for-profit and NGO-operated facilities. In contrast to the MOH's estimate stated in the PAD that 12 percent of all private providers are registered, a census conducted by the Strengthening Health Outcomes through the Private Sector (SHOPS) project found that 47 percent of private health facilities and 83 percent of private pharmacies were registered with the relevant agency.

Because the private health sector in Benin is large and dispersed, the evaluation team, in consultation with the USAID Health Team, focused on the ProFam clinic franchise operated by PSI/ABMS.

Sub-result 2.1: Improved public sector policies, oversight and supervision of private sector service delivery

The IFHP PAD envisioned that the ASSIST project (now called the ANCRE project) would work with the DSME to develop an accreditation system for private providers. ANCRE was also expected to facilitate professional development opportunities and quality improvement measures. For the most part, those mechanisms have not yet been developed, because the ANCRE project did not start until October 2014. However, the HFG project has worked on creating the National Private Sector Platform that is intended to serve as an interlocutor between the private sector and the MOH, which will be an important collaborator for ANCRE as it begins to implement private sector activities.

ARM3 facilitated registration of approximately 100 private providers to date. According to the SHOPS private health sector census report, of private facilities registered before 2014, 22 percent had not received any sort of supervisory or accreditation visit from the MOH within the past year and 16 percent had never received an accreditation visit.⁷

Sub-result 2.2: Improved quality service delivery, especially for women and young children, at private health facilities

ARM3 introduced ETAT at private and NGO hospitals as described in the PAD, and ARM3 worked with 350 private facilities to standardize malaria diagnosis and treatment according to national guidelines.

Among the four ProFam clinics visited by the evaluation team, one provides child immunizations when a child is brought in for services. The other ProFam clinics do not offer childhood immunizations; the clinic managers reported that they refer clients to public health facilities for immunization.

⁷ Carmona, Andrew, Sean Callahan and Kathryn Banke. November 2014. *Benin Private Health Sector Census*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

Three of the four PSI-supported ProFam clinics visited by the evaluation team offer maternal health services, including antenatal and postnatal care as well as labor and delivery. The clinic owners/managers reported that the partogram is routinely used to monitor labor and active management of the third stage of labor (AMTSL) is consistently practiced. Only one of the ProFam clinics visited has a delivery room that meets national norms for space, light, ventilation, equipment and cleanliness. Two of the four ProFam clinics visited have trained staff and equipment to provide Basic EmOC.

Three of the four ProFam clinics visited reported offering a full range of short- and long-acting reversible contraceptive methods. The fourth clinic currently does not have a provider trained to provide long-acting reversible methods such as IUDs and implants.

The SHOPS private sector census reported that 75 percent of private facilities had stocks of cotrimoxazole and amoxicillin; ACTs were in-stock at about 50 percent of the facilities and almost two-thirds of the pharmacies, but RDTs were not widely available in these facilities. The SHOPS census also found that the first-line treatments for uncomplicated pediatric diarrhea, oral rehydration solution, zinc and the Orasel-Zinc diarrhea treatment kit, “were not widely available at private facilities and pharmacies and were frequently out of stock in those facilities that did report carrying them regularly.”⁸

Sub-result 2.3: Strengthened private health sector providers, as both for-profit and not-for-profit businesses

The ProFam clinic managers that attended business training provided by SIFPO/PSI found the training to be extremely useful. One clinic manager interviewed had not yet received such training but was eager to attend.

As noted under IRI, USAID has contributed to the establishment of the RAMU by technical assistance provided by the HFG project, although the SHOPS census report found that as of November 2014, only 3.5 percent of private pharmacies accept RAMU insurance for prescription payment. RAMU is open for enrollment in fourteen of the country’s thirty-four health zones.

IR 3: Improved preventive and care-seeking behavior of an empowered population

This IR is intended to increase use of health services and healthy behaviors and strengthen community engagement.

Sub-result 3.1: Increased appropriate health-promoting behaviors made by households, and especially women

According to the MOH Annual Health Statistics reports, there has been an increase in use of services. For example, the percentage of children 0–5 years old that were brought to a facility for examination increased 16.13 percent from 81.2 percent in 2011 to 94.3 percent in 2013. Overall use of services increased from 45.5 percent in 2011 to 51.4 percent in 2013, an increase of 13.21 percent.⁹

⁸ Benin Private Health Sector Census, 2014.

⁹ Ministère de la Santé. Annuaire des Statistiques Sanitaires, 2011, 2012, 2013.

The ARM3 project developed a behavior change communication (BCC) strategy and conducted BCC activities to promote use of malaria prevention measures, e.g., IPTp and use of LLINs, and to encourage health-seeking behavior. Future BCC activities will be handled by the local NGOs managing the Community PIH activities, although ARM3 will continue to support promotional events such as World Malaria Day. At the time of this evaluation, the effectiveness of ARM3's BCC activities was not known because a planned evaluation of the BCC strategy had not yet been conducted. That evaluation is scheduled for May and results are expected in June.

The evaluation team does not have data about what specifically contributed to the increase in health-seeking behavior, but focus group discussion participants expressed increased satisfaction with the quality of services provided. Participants in three focus groups said health personnel now treat them with more respect than previously and that health workers counsel them individually and in private. One participant said, "I'm at ease with the health worker who ensures discretion and talks with me where no one else can hear." Participants in one group said they appreciated receiving LLINs during ANC consultations and getting clear instructions about giving medicine to their children. Participants in the three discussions said medicine is now more regularly available at the health facility than in the past.

In addition to BCC and improvements in service quality, increases in use of health services may be influenced by the Government of Benin's policy to provide services for malaria diagnosis and treatment and caesarian section free of charge.

Sub-result 3.2: Informed families make appropriate choices on accessing public and private health services and commodities

Cultural norms of behavior that give men authority to make decisions about use of health services continue to be a hinder access to care for women and children. As most people have to pay for health care out-of-pocket, men with limited financial resources may be reluctant to give their wives permission to seek care for non-emergency situations. However, according to the 2013 MOH service statistics report, females account for 45.2 percent of use of all health services versus 39.8 percent for males. Focus group participants noted that some women have their own sources of revenue and therefore do not need their husbands' permission to get health care.

Under sub-result 3.2, the PAD specifically refers to improving geographic and financial access to medium- and long-term contraceptive methods. CHWs are authorized to distribute condoms and pills. NGO program managers interviewed by the evaluation team reported that newly recruited CHWs are not distributing contraceptives because they have not yet been trained for FP. The NGOs said that there were no FP trainers available at the departments or zones. However, other CHWs that have been in service longer and have been trained in FP distribute condoms and pills in their assigned communities. Injectable contraceptives, implants and IUDs are available only at health facilities where there are trained providers.

CHWs conduct household visits to advise clients about health issues, particularly malaria prevention and child health (diarrhea, ARI). Participants in the FGDs conducted by the evaluation team said the CHWs are a major source of health information.

Sub-result 3.3: Strengthened community-level contribution to health sector decisions and financing

In addition to work on development of the national health insurance program, the HFG project has also provided technical assistance to expand and strengthen community-level health insurance organizations called mutuelles. HFG also provides technical assistance to the mutuelle umbrella organization, the Conseil National des Structures d'Appui a la Mutualité Sociale to expand the networks of mutuelles.

Mutuelles cover routine care such as basic primary and curative services, antenatal and postnatal consultations and normal deliveries. They do not cover major medical expenses for surgery, pregnancy and delivery complications or caesarian sections

Despite the growth of the mutuelles, in the areas visited by the evaluation team, health care is still overwhelmingly funded by individual out-of-pocket payments. Facility managers and personnel estimated the following as sources of funding for health care:

- 90-95 percent individual-household out-of-pocket
- 4 percent indigent fund
- 2-3 percent mutuelles

In Borgou/Alibori where there is a higher concentration of mutuelles, the proportion of clients that belong to the plans is higher. The director of the Tchaourou Zonal Hospital reported that approximately 15 percent of their patients are members of mutuelles, and therefore have lower out-of-pocket payments. The director also reported that the mutuelles are six months late in paying the hospital for services rendered.

High out-of-pocket expenses are a barrier to health care whether provided by private or public facilities on a fee-for-service basis. In government-run facilities, malaria treatment and caesarian sections are free of charge according to government policy as a means to encourage prompt care-seeking behavior.

Managers at two zonal hospitals reported that the government's policy of free malaria treatment and Caesarian sections is putting them in financially precarious positions. The Cové Zonal Hospital has not been reimbursed for malaria services since the end of 2013 or for Caesarian sections since September 2014. The total owed to the hospital is 52.6 million FCFA (approximately US \$876,000). The Tchaourou Zonal Hospital reported similar problems with non-reimbursement of services.

Community Health Workers (CHW)

The activities of CHWs as the implementing agents of community PIHI services contribute to increasing access to health services. Many of the community-level results are included in the previous section. Given the importance of the Community PIHI strategy and the work of the CHWs, there are some specific issues that should be addressed.

Unlike the health personnel at facilities, CHWs are volunteers and are not employed or regularly paid by the MOH, NGOs or projects and programs that depend on them to carry out community-level activities. Local NGOs have a long history in Benin and have worked with

various USAID projects since 2009. Five local NGOs had subcontracts with ARM3 from 2013 to 2014 to manage the CHW activities in five health zones during a bridge period defined under the PAD.

Rather than working with NGOs as subcontractors throughout the life of the ARM3 project, under the IFHP USAID made a strategy change, removing local NGO-managed activities from ARM3. Based on a competitive procurement process, NGOs were selected and issued awards in October 2014 to manage strengthening and expansion of Community PIHI activities. As a result, two of the previously supported local NGOs graduated to direct funding and increased their coverage areas to two health zones each. A new local NGO partner was also identified. This change is consistent with USAID Forward and is intended to build capacity of local organizations as implementing partners and to develop a more stable and sustainable approach for community-based activities.

There are thousands of CHWs nationwide. USAID is supporting Community PIHI managed by the local NGOs in five initial zones, then will support scale-up activities to another five for a total of 10 zones. Other donors are supporting the work of CHWs in other zones.

In the zones supported by USAID, training of CHWs for provision of Community PIHI will be done in collaboration with ARM3, ANCRE, the MOH and other USAID projects with a community health component. Many CHWs that were active under ARM3 are now working under the oversight of the NGOs and new CHWs have been recruited.

USAID (and other donors) supported the MOH to develop national guidelines for Community PIHI to standardize the approach so that it is implemented consistently nationwide, regardless of donor or project support. The Community PIHI guidelines document is an important part of the foundation on which the approach can be scaled-up, standardized and monitored.

Key informants interviewed by the evaluation team, including MOH officials, departmental and zonal health managers and the local NGOs, are optimistic about the potential of the CHWs to increase access to services in remote areas, but there is also widespread recognition of the challenges that have to be resolved to ensure the long-term viability of the Community PIHI strategy. According to key informants, the priority issues are:

1. Finding sustainable mechanisms for payment of a monthly “motivation” of FCFA 10,000 (approximately US \$16.00): Because the CHWs are volunteers, they have no official affiliation with an organization or the MOH and no organization is legally obligated to pay them. The MOH recognizes that the CHWs are essential to the success of Community PIHI but does not have the resources to pay the monthly motivation, and donors are reluctant to take on motivation payments that will end when a project ends or priorities change. The local NGOs that will oversee the Community PIHI activities with USAID support will pay the monthly motivation, which is budgeted in the agreements with USAID. Staff of both NGOs interviewed by the evaluation team cited finding sustainable payment mechanisms as a critical issue.
2. Improving collaboration with the health zones and health centers: The CHWs are not employees of the MOH, but the Community PIHI strategy requires close collaboration between the health centers and the CHWs for training, supervision, client referral, supply management and reporting. At the time of the evaluation, staff of the NGOs interviewed (Dedras and

Sian'son) reported that they were having difficulties arranging coordination and planning meetings and joint supervisory visits with health zone and health center staff.

3. Strengthening engagement of local authorities in Community PIHI strategy: Involvement of local authorities such as mayors, community councils and civic groups is weak. Greater engagement of local authorities is important to strengthen the linkages between communities and the CHWs and to identify local resources that will sustain the strategy over time.

4. Improving supply management: The NGO staff interviewed by the evaluation team reported that CHWs have periodic shortages of RDTs, ACTs, antibiotics, condoms and oral contraceptives. There are two aspects to supply management problems: Zonal coordinators and health center do not understand that CHWs are supposed to obtain supplies and commodities from the health centers, and CHWs have poor supply management skills. The NGOs will work on developing the supply management skills of the CHWs with training and supervision, and will continue to communicate with health zones and health centers about resupply of commodities.

5. Reporting on services activities: The NGO staff interviewed said there are multiple CHW reporting forms developed by Africare/PILP, ARM3, etc. that are being used while they wait for the MOH to validate a new form that will incorporate all the Community PIHI services that the CHWs provide.

Factors contributing to success

USAID/Benin is widely acknowledged by MOH officials at all levels as an essential partner. Key informants expressed their appreciation for USAID's support to the health sector and the constructive relationships that exist between the MOH and the USAID Health Team.

The MOH's PIHI strategy is intended to improve the quality of health services and contribute to the integration of services in order to better serve client needs. Support for training and supervision of health personnel and improved health systems provided by PISAF, ARM3, PSI/ABMS and other USAID-funded projects were noted as important contributions. The Guidelines for Community PIHI, developed with the support of USAID and other donors, will be an important tool for standardizing the way PIHI is implemented at the community level.

It is too early to assess the effectiveness of USAID's direct funding of local NGOs; however, the NGO managers interviewed welcome the approach and see it as an affirmation of their capacity as IPs. The DDS of Borgou/Alibori expressed his satisfaction with the NGOs thus far and said there is good collaboration between the NGOs and the MOH.

The NGO managers said the assistance provided by APC project has been extremely helpful in clarifying the roles of the various organizations working on community PIHI. APC is also providing assistance in development of the NGO workplans and budgets and reporting procedures to ensure that USAID requirements are met.

The work of the HFG project and the SHOPS assessments have helped create an opening for a dialogue about the role of private sector and have contributed to the registration of approximately 100 private clinics.

Best Practices

IFHP implementation has introduced and scaled up various best practices to improve quality of and access to services and strengthen the health system in Benin. Among the best practices being used are the following:

- Use of RDT and microscopy for improved diagnosis of malaria and treatment with an effective ACT following confirmed diagnosis of malaria.
- ETAT that focuses rapid medical attention on patients brought to hospitals with symptoms of severe malaria.
- CHW trained and supervised to provide PIHI services at the community level as a means to increase access to basic care and health information.
- Decentralized authorization and task-shifting from higher level health facilities to peripheral levels and to CHWs. For example, CHWs are authorized to treat children with acute respiratory infections and pneumonia with antibiotics. Health personnel at peripheral health centers are trained to provide long-acting contraceptive methods such as implants and IUDs.

AMTSL and the use of the partogram to monitor labor progress are additional best practices used in Benin that have been strengthened with USAID support in the past; they are expected to receive support now through the ANCRE project.

Gender

Aspects of gender norms have been discussed in various documents, however, the evaluation team noted an effect of gender bias that had not been mentioned elsewhere. The newly developed national guidelines for Community PIHI established criteria that candidates must meet to be selected as CHWs. Literacy is a new selection criterion that women are less likely to be able to meet than men. According to NGO (Dedras) program managers interviewed by the evaluation team, CHWs recently recruited for the Community PIHI programs are mostly male, which may be the unintended result of literacy being a basis for selection. In Basilla, the NGO made an effort to retain existing female CHWs who do not meet the new literacy requirement by assigning non-literate women to a promotional package for Community PIHI, versus the complete PIHI package that includes service provision. However, CHWs working on the promotional PIHI package are not eligible for the monthly motivation payment.

2. WHAT WERE THE OBSTACLES FACED AND LIMITATIONS OF IFHP, INCLUDING FACTORS THAT HAVE CONTRIBUTED TO THESE SHORTCOMINGS?

The implementation and results of IFHP have been affected by various obstacles in the design of IFHP or that are the result of changes in implementation plans:

Multiple vertical projects to achieve integrated health services: IFHP is intended to support the MOH's PIHI strategy, which is based on the provision of integrated health services. However, the ARM3 project, the main USAID-funded project in operation since the start of IFHP, is focused on malaria and HSS for HMIS and supply chain management. When ANCRE starts supporting service delivery activities the project focus will be on MCH, family planning and HSS. There is geographic overlap between the projects that can facilitate collaboration if

well-managed, but vertical projects have specific indicators and results that have to be met, which frequently do not foster integrated services or systems.

Two-year gap between bilateral projects PISAF and ANCRE: Between approval of the PAD in October 2012 and the start of the ANCRE project in October 2014, there was no bilateral health project focused on MCH and FP provided through the public sector. Although the PAD anticipated a follow-on MCH/FP project by the middle of FY13 “at the earliest,” a project award was not made until the last quarter of FY14. Achievement of IFHP results is predicated on the performance of multiple projects, but ANCRE, the main MCH/FP project and critical to the overall success of IFHP IRs 1 and 2, did not exist for the first two years of IFHP. ANCRE has an anticipated US \$9.6 million in funding for four years, which may be too little and too short for the work required to produce results in health systems; these results require costly hardware and software, as well as improved integrated service delivery in both the public and private sectors, which requires trained personnel and the necessary equipment and infrastructure to provide quality services.

De-scoping of the ARM3 project: ARM3 started before the current PAD, but the project is an essential component of the IFHP and is incorporated in the PAD. According to the PAD, “[ARM3] was awarded with a life of project of US \$30 million, but will be partially de-scoped to US \$20 million, freeing up funding according to USAID’s policy direction for greater implementation through host government entities and local partners.” Despite this planned reduction in the project budget explicitly stated in the PAD and letters from USAID confirming the planned change, the ARM3 consortium partners were unprepared when the de-scoping occurred in 2014. Subagreements with two of the international partner organizations were terminated and staff were laid off. Several of the MOH department and zonal staff that were interviewed by the evaluation team stated that they do not know why ARM3 activities were curtailed or why there was a change in strategy.

Government-to-government (G2G) funding: Consistent with the USAID Forward policy of giving development assistance funds directly to host governments, USAID/Benin anticipated establishing G2G agreements with several divisions of the MOH and other local institutions. As explained in the PAD, “Rather than the previous model of a few large cooperative agreements, this program will focus operations and financial support to capable host government agencies and local organizations to build country ownership.” The LMG project worked with the Institut Régional de Santé Publique to set up training courses to develop national capacity to manage U.S. Government funds. As yet, G2G agreements with MOH units have not been established. Direct funding agreements have been made with local NGOs, which are receiving technical and management support from APC to ensure that they fulfill USAID financial management requirements.

Slow progress on private sector strengthening: PSI/ABMS has expanded and strengthened their social marketing activities and the ProFam clinic franchise with assistance from USAID and SIFPO/PSI. PSI/ABMS also receives support from other donors such as UNFPA, KfW, the Global Fund, Kingdom of the Netherlands and UNICEF. USAID has funded other activities to foster more collaboration between the MOH and the private health sector, e.g., the SHOPS project assessment of the private health sector and census of private health facilities. The HFG project has worked on creating the National Private Sector Platform that is intended to serve as an interlocutor between the private sector and the MOH. Registration of the platform as a

legal association is underway. ARM3 facilitated registration of private providers and has worked with 350 private facilities to standardize malaria diagnosis and treatment according to national guidelines. Additional training for private providers was put on hold because the MOH requested that ARM3 prioritize training for public sector providers. The steps that have been taken are important, but the bigger picture for private sector strengthening described in the PAD under IR 2 has not been realized for the most part. Other than the PSI/ABMS social franchise network of clinics and some facilities run by faith-based organizations, there is no organization that has been able to serve as focal point for collaboration with the private health sector, which is large and unwieldy. ANCRE has a mandate for improving the quality of services offered by the private sector and hopefully will be able to implement activities in collaboration with the newly created National Private Sector Platform.

Unpaid volunteers as the backbone of the community PIHI strategy: Among people interviewed by the evaluation team there is widely expressed concern that the community PIHI strategy as currently functioning is not sustainable. Volunteers are selected by communities to serve as CHWs and are supposed to be linked to the health centers of the MOH, but they are not employees of the MOH and do not receive regular salaries. The MOH recently stipulated that CHWs should receive a minimum motivation payment of 10,000 FCFA per month (approximately US \$16.00) for carrying out Community PIHI activities. Payment is expected to come from projects and partners that use the CHWs for implementation. For example, the local NGOs that are directly working with USAID to scale-up Community PIHI pay the motivation fees during monthly meetings with the CHWs. When projects end or donors shift their focus, the MOH has no funds to continue payment, despite the fact that implementation of the Community PIHI strategy is a national priority to increase healthcare coverage. Identifying viable ways to sustain the payments from local sources is a critical issue that must be addressed if the Community PIHI strategy is to survive.

3. TO WHAT EXTENT HAS THE ARM3 PROJECT CONTRIBUTED TO THE COVERAGE AND PERFORMANCE OF MALARIA INTERVENTION IN BENIN?

ARM3 started in October 2011, one year before the approval of the PAD for IFHP, and it is scheduled to end in September 2016. ARM3 is funded by PMI and jointly managed by the PMI partners, USAID and CDC. ARM3 is a key project of IFHP and the main USAID/PMI instrument for supporting the NMCP. In fact, the project is one of the NMCP's most important sources of technical and financial support since other donors including the World Bank and the Africa Development Bank withdrew their support and redirected funds to support performance-based financing activities.

The NMCP has an ambitious vision of eliminating malaria as a public health problem by 2030. As malaria currently accounts for over 40 percent of outpatient consultations in Benin and is the leading cause of death among children under 5 years of age, that vision will be difficult to realize.

To support the NMCP in carrying out the National Malaria Strategy, the ARM3 project has three results: (1) to improve malaria prevention programs; (2) to improve malaria diagnosis and treatment; and (3) to strengthen the national health system's capacity to deliver and manage quality malaria treatment and control interventions.

Activities and Results

ARM3 works at the national level in close collaboration with the NMCP on policy and institutional strengthening activities. At the implementation level, ARM3 works in all departments and in 34 health zones. In addition to its work with the public sector, ARM3 has worked with private providers to improve diagnosis and treatment of malaria according to national guidelines and forged an innovative partnership with CEBAC-STP, a network of private enterprises, for prevention campaigns and distribution of LLINs.

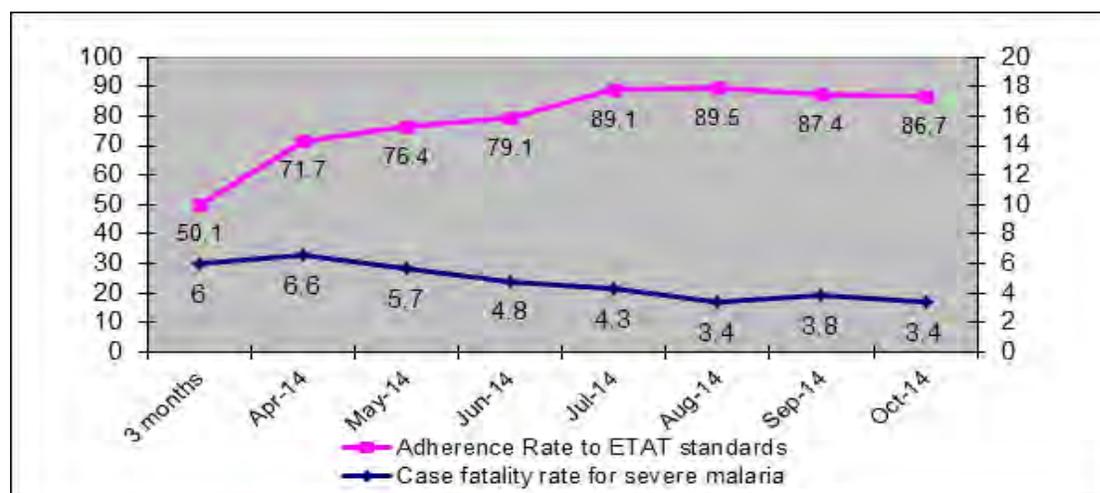
ARM3 has provided assistance to the NMCP and DSME for revisions and updating of national policies, guidelines and procedures. The national policy on IPTp was updated based on WHO recommendations. ARM3 has assisted the NMCP to develop procedures and criteria for LLIN distribution. Training materials for pre-service and in-service training have been updated.

To build capacity of health personnel, ARM3 has supported a large number of training activities for malaria prevention, diagnosis and treatment. The bulk of training supported has been for health personnel working in the public sector, but health workers from private facilities have also been trained. The project has also provided assistance to develop supervision tools and procedures, train supervisors and conduct supervision visits. The training and supervision appear to be improving performance according to the indicators: For example, the proportion of women attending ANC clinics that received IPTp2 increased from 28 percent in 2011 to 45 percent in 2014, an increase of 61 percent. Distribution and promotion of use of LLINs has also been an important activity under Result 1 for malaria prevention. Use of LLINs rose from 19.6 percent (DHS, 2006) to 75.5 percent (DHS, 2012).

To support the MOH strategy of increasing access to services, ARM3 developed a program of Integrated Community Case Management (iCCM) that was undertaken with five NGOs in northern areas of the country. ARM3 provided assistance for preparation of training materials, development of an implementation plan, and training of trainers and establishment of supervision systems. More than 1,200 CHWs were trained in the complete iCCM package for diagnosis and treatment of malaria, diarrhea and pneumonia. Work on iCCM ended in 2014 as a result of a reduction in project funds and establishment of USAID agreements with local NGOs to manage CHW activities.

The ETAT protocol, originally introduced by the PROSAF project, has been scaled up nationwide and is used in approximately 90 percent of all hospitals, both public and private. ARM3 implemented ETAT in 25 hospitals in two phases. Use of ETAT is associated with a 48 percent reduction in the case fatality rate due to severe malaria.

Figure 1. Adherence to ETAT for Severe Malaria and Case Fatality Rate in 12 Hospitals



Source: ARM3 ETAT Report

ARM3 has worked to improve collection, management and use of malaria data in order to make monitoring and surveillance more accurate and effective. ARM3 has provided technical support to strengthen the national RMIS. In the health facilities visited by the evaluation team, various performance indicators (mortality rates, dropout rates/lost views, stock-outs of ACT and/or RDT) are calculated and recorded in the individual files and the database, as required by the RMIS and Logistical Management Information System (LMIS), national HMIS and MEDISTOCK. According to ARM3 reports, RMIS reporting increased from 49 percent to 96 percent in the public sector and from 21 percent to 87 percent in the private sector from the baseline in 2011 through December 2014.

CommCare, a mHealth application, was piloted in two health zones, Tchaourou and Bassila, to test use of mobile phones for reporting community health data. The pilot was assessed and found that: 93 percent of interviewees expressed good knowledge of the system and report transmission through CommCare; 84 percent of CHWs and 100 percent of statisticians that used CommCare found it to be a fast and effective way to transmit data. The report of the CommCare assessment is available.¹⁰

Improving supply chain management has been a large undertaking for ARM3. The Medistock system for commodities management has been upgraded several times and expanded to the 34 health zones. 100 percent of health zone managers, 77 percent of health zone pharmacy managers and 18 percent of zonal statisticians were trained in use of MEDISTOCK. People interviewed by the evaluation team that are familiar with MEDISTOCK said they like the system. However, three pharmacy managers at zonal hospitals visited by the evaluation team said that although they were trained on MEDISTOCK they cannot use it, either because they don't have a computer or the computer that is available isn't powerful enough to run the program. At the peripheral level, where supply management is paper-based, 35 percent of staff with responsibility for stocks said they have not been trained in supply management. There

¹⁰ ARM3. Assessment Report of ARM3's Implementation of the Pilot CommCare Project in Tchaourou and Bassila in Northern Benin. March 2015.

have been many improvements but there continue to be disruptions in the availability of medicines and supplies: In Year 2, 30 percent of facility had stock-outs of all ACT formulations and in Year 3, 39 percent reported stock-outs. Stock-outs of SP used for IPTp are also periodically reported.

ARM3 organized the first quantification exercise for malaria commodities forecasting for 2014 and 2015 based on consumption. As consumption-based forecasting becomes routinely used, supply disruptions and stock-outs are expected to decline.

ARM3 developed a BCC strategy to mobilize communities and increase the visibility of malaria prevention. BCC activities supported by ARM3 included:

- Broadcast eight different talk shows and multiple malaria spots through a partnership with 19 radio stations. Messages were diffused in 22 languages throughout the country.
- Supported commemoration of the annual World Malaria Day events in Cotonou and at the departmental level.
- Produced and distributed over 300,000 flyers on topics including LLIN use and upkeep, SP use and ACTs for uncomplicated malaria.
- Broadcast and rebroadcast several TV spots in Year 2 featuring a famous African Cup soccer player promoting the consistent use of LLINs. Having a soccer star deliver the LLIN message, which has usually targeted pregnant women and children under 5, was intended to reach men.
- Trained more than 730 front-line health providers in interpersonal communication for malaria in pregnancy.
- Supported 60 community theater performances by five regional theater groups about malaria themes including community case management.

Other BCC activities carried out with ARM3 support are noted in Annex VIII. A planned evaluation of the effectiveness of the BCC activities is scheduled for May 2015. However, while by no means fully attributable to ARM3, the MOH Annual Health Statistics reports show an increase in LLIN use by children under 5 and pregnant women suggest a positive effect.

Table 5. LLIN Use

Indicator ¹¹	2011	2012	2013
Percentage of children under 5 that sleep under a LLIN	64%	80%	71%
Percentage of pregnant women that sleep under a LLIN	60%	71%	76%

Other ARM3 activities and outputs to date are summarized in Annex VIII.

Challenges

Numerous challenges affect the ARM3 implementation and achievement of results. Malaria is highly endemic in Benin and is responsible for a high proportion of morbidity in all age groups of the population. Malaria is particularly dangerous for children under 5 and pregnant women, but malaria also hinders school attendance and performance of older children and reduces

¹¹ Ministère de la Santé. *Annuaire des Statistiques Sanitaires*, 2011, 2012, 2013.

productive capacity of adults. According to the PAD, malaria is a “leading challenge to development” in Benin.

ARM3 has made important contributions to improving diagnosis and treatment of malaria, but malaria remains the leading cause of morbidity in Benin. This suggests that more attention is needed for prevention and vector control. One key informant said, “We keep passing out tablets to treat malaria but we’re not adequately addressing the cause of the disease.” A study published in 2014 suggests that stratifying the country into high and lower transmission zones could be useful for planning cost-effective vector control strategies.¹²

A major challenge for ARM3 was the “de-scoping” or reduction of the project budget by almost \$10 million in mid-2014. As described in the IFHP PAD, funds were redirected for G2G agreements consistent with the USAID Forward strategy. As a result of the de-scoping, two of the project partner organizations had their agreements cancelled and staff were laid off. Agreements that had recently been signed with local NGOs to manage the iCCM activities were also cancelled. (New agreements were established by USAID to provide funding directly to local NGOs using the de-scoped funds.) Responsibility for some other activities was transferred to the NMCP, ANCRE and APC. See Annex VIII for a summary of changes that have occurred during Years I-4.

Human resource constraints are an ongoing challenge for ARM3 and other IPs working in the health sector. The NMCP is described in the PAD and MOP as having weak professional capacity in terms of the number of personnel employed and the caliber of the technical expertise. As a result, NMCP’s ability to plan, manage and coordinate activities among partners is limited and the approval process for policy revisions is slow.

The MOH health facilities are also under-staffed and there is frequent rotation and turn-over of health personnel. Departures of staff that have been trained in revised protocols for IPTp or case management result in facilities not having clinical capacity to provide quality services. Despite training a large number of health personnel, there is constant need for training newly recruited staff or conducting refresher training for staff that need technical updates. For example, as reported in the previous section, ARM3 supported training of 1,913 health workers and the proportion of ANC clients getting two doses of SP more than doubled since the start of the project. As of January 2015, the IPTp guidelines have been revised to three doses of SP for all pregnant women. Despite training 1,043 health workers nationwide on the revised IPTp guidelines,¹³ the evaluation team found that many health workers were following the old guidelines of two doses unless the woman is HIV-positive, in which case three doses would be given.

For the evaluation team, one of the problems encountered while trying to assess the progress of ARM3 (and other IFHP projects) toward achievement of results is the lack of quantifiable indicators. Project documents, the MOP and other materials that were reviewed report process indicators such as the number of health workers trained, but they do not indicate the total number of health workers, making it difficult to determine whether a large or a small proportion of the workforce has been trained. If a project is considered nationwide in scope,

¹² Gnanguenon et al. *Transmission patterns of Plasmodium falciparum by Anopheles gambiae in Benin*. *Malaria Journal* 2014, 13:444.

¹³ PMI. Benin Malaria Operational Plan. 2015.

indicators are needed to measure the degree to which activities achieve that scope.

Project Cost Analysis

See Annex VIII for a summary of ARM3 budget and project expenditures from October 2011 through December 2014.

4. IN WHAT WAYS DID USAID/BENIN'S IMPLEMENTING PARTNERS COLLABORATE WITH EACH OTHER, THE MISSION AND OTHER DONOR PROJECTS, AND WHAT COLLABORATING OPPORTUNITIES WERE MISSED?

USAID organizes a monthly meeting with the chiefs of party and quarterly program reviews with the IPs to share updates on project progress and discuss challenges, achievements and next steps for the upcoming quarter.

The DDS and MCH director for Borgou/Alibori commented that there are many projects and donors, each with their own priorities. They said working with multiple projects is time consuming and not particularly effective, since there is frequent overlap and duplication.

ARM3 is the only project that has an office in Parakou (Borgou/Alibori), and that is the only office the project has outside of Cotonou. The de-scoping of the ARM3 project and subsequent staff reductions has reduced the ARM3 presence in the zones and departments where the project operates. Given distances and road conditions, the few staff remaining in Parakou cannot provide adequate "face time" with MOH collaborators in other departments and zones.

The lack of presence of project staff in the departments and zones also contributes to a perception of inadequate collaboration and coordination among projects and between projects and the MOH. Department and zonal managers said more frequent visits by project and USAID staff would be beneficial.

V. CONCLUSIONS AND RECOMMENDATIONS

The following conclusions and recommendations respond to evaluation question 5: Based on evaluation findings, what are recommendations for the final year of the ARM3 and future (follow-on) program(s), with a focus on priority strategies and activities?

1. Finding: IFHP objectives have been partially achieved, primarily but not exclusively based on ARM3 achievements in malaria services and some improvement in supply chain management for malaria commodities.

- **Conclusion:** The two-year gap between USAID-funded projects with a focus on MCH-FP services has limited IFHP's achievements thus far in improving integrated family health services.
- **Conclusion:** Implementation of a new MCH-FP project is expected to provide support that will lead to improved quality and access to services and better integration of MCH-FP and malaria services.
 - **Recommendation:** To achieve integrated family health services, USAID/Benin and the IPs should work with the MOH to determine how to train and supervise health personnel to strengthen integrated service delivery. Rather than stand-alone training and supervision of malaria or ANC or FP, training and supervision may need to be revised to emphasize service delivery that addresses multiple health needs in a single client visit.

2. Finding: The HMIS is cumbersome and does not provide reliable epidemiological data.

- **Conclusion:** Multiple reporting forms, programs and procedures are being used at the same time, creating parallel systems that require additional effort and do not increase efficiency.
 - **Recommendation:** Specialized technical assistance is needed to revamp the HMIS. Rather than creating tools and programs that work for only one or two services, are tailored for the reporting requirements of a donor or project, or cannot be used at the periphery, the MOH needs to develop a comprehensive HMIS that can facilitate effective planning, management and performance monitoring.
- **Conclusion:** Record keeping and reporting of service statistics by many health facilities is unsatisfactory. Service statistics are not regularly recorded, consolidated and kept at a central point within the facility, which contributes to poor aggregation of data and accurate reporting from the facility to the zonal office.
 - **Recommendation:** Streamlined procedures, recording guidelines, reporting instruments and schedules should be developed.

3. Finding: Development of national guidelines for Community PIHI is an important step in standardizing the strategy, but there are critical issues that must be resolved for long-term sustainability and institutionalization.

- **Conclusion:** Critical issues in the Community PIHI strategy that will undermine the effort if not resolved include: sustainable sources of payment of the CHW monthly motivation fee; reliable mechanisms for providing CHWs with medications, commodities and supplies; improved skills of CHWs for supply management; effective collaboration of Health Zone and Health Center personnel and the CHWs.
 - **Recommendation:** ARM3, ANCRE, APC, local NGOs and the MOH must work together to find sustainable solutions and put them in place during the next six months.

4. Finding: Use of modern contraceptive methods remains low in Benin, and far below the 15 percent CPR objective of the Government of Benin and IFHP.

- **Conclusion:** Strategies to increase access to FP services are needed to increase use and reduce unmet need for FP.
 - **Recommendation:** Service delivery approaches such as mobile outreach should be implemented to augment FP services provided at health facilities in order to increase access in rural areas.
 - **Recommendation:** Training of health personnel is needed to ensure that skilled providers are available at all facilities. FP training should include dispensary staff as well as maternity staff to foster more service integration and increase service availability.
- **Conclusion:** Shifts in method preference indicate increased need for trained providers and availability of methods and related expendable supplies.
 - **Recommendation:** Training of service providers for implant insertion and removal should be conducted to respond to increased demand for the method.
 - **Recommendation:** In addition to ensuring regular stocks of implants, supply chain management must include the related supplies needed for implant insertion and removal, e.g., betadine, gauze, bandages, sterile drapes, etc.

5) Finding: Many MOH facilities do not meet national standards for space, lighting, ventilation, staffing, equipment, etc.

- **Conclusion:** Physical conditions at many of the public health facilities visited are not conducive to the provision of quality services.
 - **Recommendation:** Facility assessments should be conducted in zones where USAID is supporting activities to determine if a facility meets the minimal standards for quality services. These data can then be shared with the facility and the district health offices to develop plans for quality improvement.
 - **Recommendation:** Based on the facility assessment, plans and specification should be developed for facility upgrades and procurement of equipment and instruments to improve the quality of PIHI services.

6. Finding: Malaria remains the leading cause of morbidity despite large investments in prevention, diagnosis and treatment.

- **Conclusion:** Continued scale-up and strengthening of diagnosis and treatment are essential, but additional attention is needed to prevent malaria and reduce the burden of disease.
 - **Recommendation:** The IPTp indicator for ARM3 and IFHP should be updated to reflect the revised policy of giving three doses of SP to all pregnant women.
 - **Recommendation:** Although pregnant women and young children are particularly vulnerable to malaria, malaria also decreases productivity among adults and school-aged children. Promotion of consistent use of LLINs by everyone is needed as one element of vector control.
 - **Recommendation:** ARM3 should work with PMI and the NMCP to identify effective vector control strategies that can be implemented in Malanville and Parakou, where there is high risk of malaria transmission and almost continuous exposure due to rice cultivation and vegetable farming. This recommendation is not intended to suggest that ARM3 should implement new vector control strategies but rather to investigate potentially effective strategies that could be tested and implemented during a follow-on project if there is one.

7) Finding: Inclusion of literacy as a criterion for CHW selection may result in fewer women being selected as CHWs.

- **Conclusion:** Since women are less likely than men to be literate, particularly in rural areas, the literacy requirement may result in a gender imbalance among male and female CHWs that provide the complete PIHI package.
 - **Recommendation:** The literacy criteria should be re-examined in order to find ways to accommodate women who have low literacy skills. Using them as PIHI “promoters” who are not eligible for the monthly motivation payment is not an adequate alternative.

8) Finding: Coordination and collaboration among USAID projects **and** between projects and the MOH, particularly at department and zonal levels needs to be improved.

- **Conclusion:** With new USAID-supported projects starting to implement activities, this is an opportune time for the IPs to improve communication and collaboration with department and zonal authorities.
 - **Recommendation:** At department and zonal levels, IPs should offer to play a secretariat function if needed to assist the DDS or zonal coordinator conduct quarterly coordination meetings with the IPs supporting activities in the area.

ANNEX I. SCOPE OF WORK

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

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW) 2/20/2015

I. TITLE: Evaluation of USAID/Benin's Integrated Family Health Program

Technical Directive Number (assigned by GH Pro): 049

II. Requester / Client:

USAID Country or Regional Mission

Africa: Benin

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

3.1.1 HIV

3.1.6 MCH

3.1.2 TB

3.1.7 FP/RH

3.1.3 Malaria

3.1.8 WSSH

3.1.4 PIOET

3.1.9 Nutrition

3.1.5 Other public health threats

3.2.0 Other (specify):

IV. Cost Estimate: GH Pro will provide a final budget based on this SOW.

V. Performance Period: (Use pull down to indicate expected start and end dates – *choose any day in the month and year on pull down calendar*)

Expected Start (on or about): 23-Feb-2015 Anticipated End (on or about): 7-Aug-2015

VI. Location(s) of Performance Period: (Indicate locations where work will be performed to implement this evaluation or analytic activity)

Benin (Cotonou and various in-country sites to priority and non-priority health zones)

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

EVALUATION:

Performance Evaluation (*Check timing of data collection*)

Midterm (IFHP) Endline (ARM) Other (specify): _

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

VIII. BACKGROUND

Background of project/program/intervention:

The USAID/Benin mission does not have a Country Development Cooperation Strategy (CDCS) but has articulated its strategy in the Global Health Initiative (GHI) Country Strategy for 2011-2015, which serves as the basis of the Benin Integrated Family Health Program (IFHP). USAID/Benin's health activities focus on (1) improving public health sector performance in delivering integrated family health services; (2) improving private health sector performance in delivering integrated family health services; and (3) improving preventive and care-seeking behaviors of an empowered population. Supporting the above are two cross-cutting GHI principles: building sustainability through health systems strengthening (HSS); and focusing on women, girls and gender equality.

In line with the USAID Forward reforms of 2011, the IFHP Program Appraisal Document made shifts towards country system investments in both government and civil society.

There have been two revisions to the initial IFHP Program Appraisal Document (PAD) since its initial development in 2012. The first revision included an additional adolescent sexual and reproductive health component in April 2013 and the second a series of revisions in planned government-to-government and Global Development Alliance partners. These adjustments impacted the mission's ability to obligate funding to its new bilateral MCH/FP program, the new Advancing Newborn, Child and Reproductive Health (ANCRE) project and Support to Community PIHI through local NGOs which are just now in their initial year of implementation. Each revision also required the need to refine the timeline and awards under the PAD based on revisions to the budget and priorities. The results framework, however, did not change during the modifications. While these major programs are in start-up, the President's Malaria Initiative bilateral project, (ARM3) project is reaching the end of its 5 year plan and the mission is in the midst of planning the follow on project.

Describe the theory of change of the project/program/intervention.

The overall development objective of the plan is to contribute to improved health of Beninese families over the next five years. The impact of our interventions will be assessed by the extent to which USAID/Benin's support enables Benin to move towards its targets of: (1) reducing the maternal mortality ratio from 327 to 125 per 100,000 live births; (2) reducing under-five mortality rate from 125 to 60 per 1,000 live births; (3) reducing the neonatal mortality rate from 32 to 20 per 1,000 live births; (4) reducing by half the proportion of deaths attributed to malaria among children under-5 using the 2011 baseline; and (5) increasing the contraceptive prevalence rate from 7.9 percent to 15 percent.

Our development hypothesis is that universal access to the quality essential health services identified in the package of high impact interventions (PIHI), delivered by both the public and private sub-sectors, combined with improved preventive and care-seeking behavior by a more empowered populace will result in the improved health status of Beninese families. We believe that delivering these interventions under responsible government leadership and enabled local organizations will lead to more sustainable and scalable approaches and programs.

To improve public sector performance, our hypothesis is that decentralized health managers and providers need to improve planning and management, accept greater accountability, assure more efficient resource transfers, strengthen information systems, and base decisions on stronger evidence. Health workers need quality training, follow-up and supervision and functional equipment. Inventory management of essential commodities needs to improve, as do skills for identification, quantification,

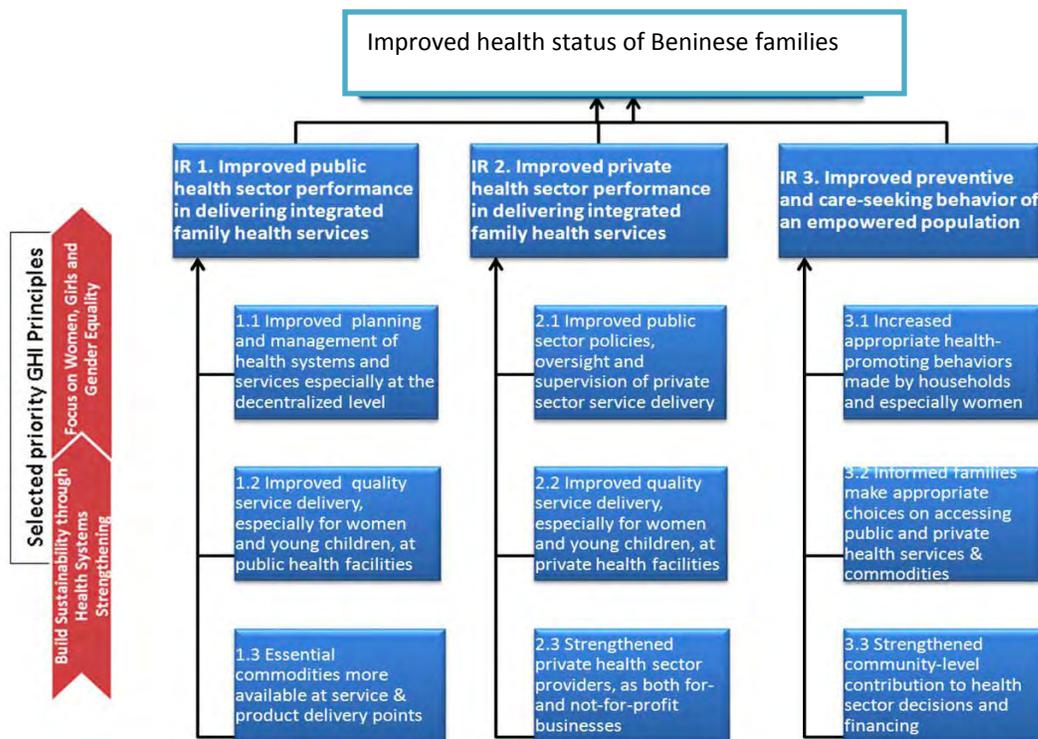
planning and ordering.

To improve private sector performance, our hypothesis is that the public sector needs greater incentives for registration and accreditation. Professional associations must play a pivotal role in this process. The public sector regulation role needs to be strengthened, including the mandate of integrating protocols, supervising service delivery, and incorporating private sector service reports. In exchange, private providers need access to public sector inputs (e.g., training, essential drugs, etc.), credit and sources of business management expertise. Private providers also need more professional networking opportunities as well as incentives to provide quality care that meets defined standards.

To improve care-seeking behaviors of an empowered populace, our hypothesis is that effective health communications messages need to reach people, financial constraints to care-seeking need to be addressed, consumer protection in health needs to improve and care delivery needs to be more respectful. Communities need to be empowered and the public sector needs to be accountable to communities.

The Intermediate Results (IRs) of the program’s logical framework are: IR 1: Improved public health sector performance in delivering integrated family health services; IR 2: Improved private health sector performance in delivering integrated family health services; and, IR 3: Improved preventive and care-seeking behavior of an empowered population. The first two results directly target health system strengthening for the public and private sectors.

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



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

Designed prior to the PAD, the ARM3 project provides national coverage but focuses primarily on 25 health zones outside of the Mono/Couffo department. However, all other projects are in-line with the PAD and its geographic focus on 10 health zones of (1) Tchaourou, (2) Cove/Zagnanado/Ouinhi, (3) Kandi/Gogounou/Segbana, (4) Djougou/Ouake/Copargo, (5) Bassila, (6) Allada/Ze/Toffo, (7) Savalou/Bantè, (8) Abomey Calavi/So Ava, (9) Cotonou II and III, and (10) Athiémé/Lokossa. Among these priority zones, the following six are targeted as potential evaluation sites because of their confluence with USAID/Benin-funded community health activities since 2009 and previous quality improvement interventions: (1) Tchaourou, (2) Cove/Zagnanado/Ouinhi, (3) Kandi/Gogounou/Segbana, (4) Djougou/Ouake/Copargo, (5) Bassila, and (6) Allada/Ze/Toffo.

At the health zone level, the evaluation will cover health management office (medical coordinator, statistician, supervisors, and community mobilizers), the zone medicines depot, hospitals and public and private health providers, and community health workers (relais communautaire). The intermediary level health departments will also be included in the evaluation in regards to health systems strengthening. It should be noted that the malaria cell is based at the department level.

In line with the intermediate result of strengthened leadership, management and governance capacity, key units of the Ministry of Health (National Malaria Control Program, Directorate of Public Health, Directorate of Maternal and Child Health, Directorate of Planning and Prospective and the Directorate of Essential Medicines) will be central to this evaluation.

IX. SCOPE OF WORK

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

To conduct a performance evaluation of the USAID/Benin Integrated Family Health Project (IFHP) (2012-2015), which addresses malaria, family planning (FP) and maternal child care (MCH) programmatic areas.

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 USAID mission, current implementing partners and the Government of Benin are the primary audience for the evaluation.

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

Results from the evaluation will be used to design the next integrated family health project appraisal document (PAD) and plan the follow on to the ARM3 (PMI) activity. The mission is interested in identifying an appropriate mix of projects that maximizes effectiveness and efficiency and supports a fully integrated health program.

D. **Evaluation questions:** Evaluation questions should be: a) aligned with the evaluation purpose and the expected use of findings; b) clearly defined to produce needed evidence and results; and c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation questions. **USAID policy suggests 3 to 5 evaluation questions.**

Evaluation Question

1. What are the best practices and achievement of IHFP, including factors that have contributed to these successes?

The IHFP aims to improve the health status of Beninese families through improved performance of the package of high impact interventions, including malaria, offered by both public and private health providers at the clinic and community levels. Two cross-cutting themes of the strategic results framework are health systems strengthening and gender. USAID/Benin needs to know to what extent its health systems strengthening efforts (HRH, HMIS, supply chain/commodities, health care financing and governance) and gender at central, intermediary and peripheral (facility, outreach and community) levels are contributing to performance. To answer this question, the evaluators need to review the results of activities both for the public and private sectors and provide recommendations on where the mission should focus their HSS and gender efforts in the future.

2. What were the obstacles faced and limitations of IHFP, including factors that have contributed to these shortcomings?

The IHFP PAD has been modified twice since it was originally approved in September 2012. Each revision reflected the need to refine the timeline and awards under the PAD based on revisions to the budget and priorities. The results framework, however, did not change during the modifications. Describe how any delays impacted the mission's ability to meet desired results and how shifting priorities were managed by staff, partners, Government of Benin and other stakeholders.

3. To what extent has the ARM3 project contributed to the coverage and performance of malaria interventions in Benin?

The Accelerating Reduction of Malaria-related Morbidity and Mortality in Benin project (ARM3), a central component of the IHFP, is approaching its completion, with 18 implementation months remaining. The purpose of the program is to increase coverage and use of key life-saving malaria interventions in support of the Benin National Malaria Strategy. This program complements programmatically the existing USAID/Benin Maternal and Child Health (MCH) program and other donor-supported malaria programs. This program seeks to achieve USAID/Benin's President's Malaria Initiative (PMI) targets in the prevention and treatment of malaria. The project started in October 2011 and was modified in June 2014 with a transfer of some activities to the National Malaria Control Program and local NGOs in line with planned strategic directions in the IHFP. As a major activity of the IHFP, it is essential to specifically document ARM3's achievements and challenges for the purpose of designing the next strategic plan. Findings should specify any factors that have contributed to the success or challenges of the project and make note of how the MOP annual review and planning process has affected performance. Recommendations should identify any specific actions/changes that should be implemented during the final year of the project and priority activities for the follow on award.

4. In what ways did USAID/Benin's implementing partners (IP) collaborate with each other, the Mission and other donor projects; and what collaborating opportunities were missed?

There are several implementing partners, government stakeholders, donors and other local and international NGOs who all play a role in supporting USAID/Benin's IHFP. The mission has tried different approaches to foster collaboration and integration of projects and wants recommendations on ways to strengthen relationships and communication. Recommendations on future collaboration should be specific and can include innovative approaches used by other missions and private sector organizations that could be adapted for the Benin context.

5. Based on evaluation findings, what are recommendations for the final year of the ARM3 and future (follow on) program(s), with a focus on priority strategies and activities.

Given levels of funding, staff size, and environmental factors, the next integrated health program needs to carefully determine the appropriate mix of activities and levels of the health system to maximize results. USAID/Benin desires to work towards a truly integrated family health program in the coming years while ensuring the successful completion of ANCRE and the need to put in place the follow on bridge activity to ARM3. Findings from this question will be used to design the next PAD and follow on to ARM 3 and therefore recommendations must be specific, actionable, relevant to the context, and provide short and longer term options where appropriate.

Other Questions [OPTIONAL]

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

Evaluation questions should consider the following program elements:

- Malaria (PMI/ARM3)
- High impact interventions package (PIHI)
- Public sector health system strengthening based on six health systems building blocks
- Private sector quality of services
- Gender
- USAID/Benin's IFHP PAD modifications during the life of the project

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

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

USAID Health Program Documents

- IFHP PAD (and amendments)
- ARM3 agreement and modifications
- ARM3 annual workplans and reports
- ANCRE RFA and cooperative agreement workplan
- Community PIHI RFA and workplans
- GHI Benin country strategy 2011-2016

USAID funded reports

- Demographic Health Survey 2012
- Health Facility Survey, 2013 (pending)
- Health Systems Evaluation, AZT HZ, 2012 (PISAF)
- SHOPS private sector assessment
- Routine Malaria Indicators Surveillance Reports, Quarterly
- End User Verification Surveys for malaria commodities, Quarterly
- Health Systems Evaluation, Zou/Collines Department, 2011 (PISAF)

External documents and reports

- Government of Benin health planning documents—PNDS 2008 - 2018, PIHI Package, revised National Malaria Strategic Plan 2011 – 2018
- UNICEF's Multi-Cluster Survey 2014 (pending)

- Annual National Health Management Information Reports (MOH)

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

- USAID/Benin Health Team leader
- PMI residential advisors and logistics specialist
- Directors/coordinators and service heads at NMCP, DSME, National Public Health Department, and Planning and Prospective Department
- Leadership teams of Implementing partners: ARM3, ABMS/PSI (SIFPO), LMG, ANCRE, APC
- Department medical coordinators, malaria cell coordinators, health zone medical coordinators, statisticians, depot staff

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

The purpose of these focus group discussions will be to gain information about target beneficiaries' use of services, reasons for using or not using services and attitudes and practices regarding health issues covered by IHFP and ARM3, such as use of bednets, FP, MCH services, etc. Discussants will include community members who represent target beneficiaries for IHFP and ARM3, including women and their partners of reproductive age, who are pregnant or were pregnant during the life of the project and parents with children under age 5. Female and male discussants should participate in separate focus groups to avoid potential influence of men over women due to culture based power differentials.

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

Using a semi-structured question guide to get feedback on the project(s), effectiveness of technical assistance provided, and recommendations for future programming, respondents will be clustered by type of work, and level of system:

- Maternity and dispensary staff from both public and private facilities
- Community health workers
- Project staff

Note: management and frontline staff should not be in the same groups to avoid undue influence of management over their staffs.

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

Comprehensive patient/client interviews from antenatal clinic and out-patient clients about level of service provided. This information will complement existing sources from ANCRE, ARM3 and project evaluations in 2012.

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

Review trends in malaria services from quarterly malaria surveillance bulletins, end-user verification surveys and the health facility survey. This includes ITN distribution for pregnant women and children under 5, intermittent presumptive treatment of malaria in pregnancy (IPTp), correct malaria case management, malaria commodity availability at point of service, and completeness and promptness of routine malaria reporting.

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

The Team will discuss the possibility of a case study at the team planning meeting, including points such

as the following:

- The progress towards confirmatory malaria testing at facility and community levels.
- LMG activities that improved SP supply or other malaria or non-malaria activity.

X. ANALYTIC PLAN

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

A qualitative and quantitative analysis of the achievements in relation to the objectives and targets of the IFHP and PMI/ARM programs will be conducted. This analysis should answer the evaluation questions.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be stratified by demographic characteristics, such as sex, age, and location. In the report, the evaluators will describe the statistical tests used.

Thematic reviews of qualitative data will be performed. Qualitative data will be used to substantiate quantitative findings, provide more insights than quantitative data can provide and answer questions where other data does not exist. All qualitative data should be documented in comprehensive notes or entered into appropriate software such as NVivo, Atlas ti or another approved software.

Use of multiple methods that are quantitative and qualitative, as well as existing data (e.g., ANCRE and ARM performance indicator data, DHS and MICs) will allow the team to triangulate findings to produce more robust evaluation results.

XI. ACTIVITIES

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

Background reading and clarification of the SOW and logistics – Several documents are available for review for this program evaluation. These include ARM annual work plans for the last four years, M&E plan, and quarterly progress reports. There are also the IFHP PAD documents and ANCRE workplan/M&E plans. The most recent DHS was in 2012.

Background reading is required by all team members who will document their questions or impressions with other team members and the mission on a common shared google doc prior to the TPM. A preliminary call with the mission is recommended to clarify the SOW purpose and evaluation questions as well as any questions pertaining to the background reading.

Team Planning Meeting (TPM)--The evaluation team will start their work with a two- or three-day TPM will be held in Benin before the evaluation begins. The TPM will:

- Share background, experience and expectations of each of the team members for the assignment;
- Formulate a common understanding of the assignment and clarify any questions on the evaluation SOW;
- Clarify team members' roles and responsibilities;
- Agree on the objectives and desired outcomes of the assignment;
- Establish a team atmosphere, share individual working styles, and agree on procedures for

- resolving differences of opinion;
- Review and finalize evaluation questions;
- Review and finalize the assignment timeline and share with other units.
- Develop data collection methods, instruments, tools and guidelines;
- Review and clarify any logistical and administrative procedures for the assignment;
- Develop a data collection plan;
- Draft the evaluation work plan for USAID’s approval
- Develop a preliminary draft outline of the team’s report; and
- Assign drafting/writing responsibilities for the final report.

Briefing and Debriefing Meetings – Throughout the evaluation the team lead will provide briefings to USAID. The in-brief and debrief are likely to include the all evaluation team experts, but will be determined in consultation with the mission. These briefings are:

- Evaluation **launch**, a call among the USAID/Benin, GH Pro and the team lead to initiate the evaluation activity and review expectations. The mission will review the purpose, expectations and agenda of the assignment. GH Pro will introduce the team lead and review the travel schedule.
- **In-brief** with USAID/Benin, following the TPM. This briefing will include the evaluation team, USAID/Benin health team, program office M&E advisor, and other mission staff as appropriate. The evaluation team will present an outline and explanation of the design and tools of the evaluation.
- The team lead will brief the mission **weekly** to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email. **Note:** *preliminary findings are not final and as more data sources are developed and analyzed these finding may change.*
- A **final debrief** will be held approximately 3 days before departure, between USAID/Benin and the evaluation team. 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 evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report.
- **Stakeholders’ debrief with IPs** will be held following the final debrief with the mission.

Fieldwork, Site Visits and Data Collection – The evaluation team will conduct site visits to ARM and ANCRE sites for data collection. This includes the departments of Borgou/Alibori and Zou/Collines. USAID/Benin proposes that field visits be conducted in a convenience sample agreed up in the SOW. The site visits will involve key informant interviews, focus group discussions and client satisfaction surveys. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

XII. DELIVERABLES AND PRODUCTS

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

Deliverable / Product	Timelines & Deadlines
■ Launch Briefing	March 2, 2015
■ Workplan with timeline	March 6, 2015

■ Analytic protocol with data collection tools	March 13, 2015
■ In-brief with Mission or organizing business unit	March 13, 2015
■ Routine briefings	Weekly
■ Raw data	March 30, 2015
■ Out-brief with Mission or organizing business unit with Power Point presentation	April 6-7, 2015
■ Draft report	April 24, 2015
■ Final report in English	May 27, 2015
■ Final report in French	June 19, 2015
■ Uploaded to DEC in 508 format	July 21, 2015

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? **10** business days for draft report.

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

Evaluation team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an evaluation specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with methodological expertise related to the
- Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for individual team members, or for the team as a whole.

Key Staff 1 Title: Evaluation team lead/senior public health program specialist (local or regional consultant) (Note: This person may have strong skills listed under other key staff, and if so, one person will be recruited for both this and the other position.)

Roles & Responsibilities: The team leader will be responsible for (1) managing the team's activities, (2) ensuring that all deliverables are met in a timely manner, (3) serving as a liaison between the mission and the evaluation team, and (4) leading briefings and presentations.

- Finalize and negotiate with USAID/Benin the evaluation work plan
- Establish evaluation team roles, responsibilities and tasks;
- Ensure the development of data collection instruments/questionnaire
- Facilitate all necessary meetings in the U.S. and in Benin;
- Ensure that the logistics arrangements in the field are complete;
- Coordinate schedules to ensure timely production of deliverables;
- Coordinate the process of assembling individual input/findings for the evaluation report and finalizing the evaluation report

Qualifications: Expertise in integrated family health programming (MCH/RH/FP/malaria) with extensive USAID program design, implementation and evaluation experience; fluent French speaker with experience in West Africa preferred. S/he must have a proven track record supervising teams in the field and producing high quality and concise evaluation reports.

- Minimum of 10 years of experience in public health, with technical knowledge and experience in integrated family health (MCH/RH/FP/malaria) interventions
- Excellent skills in planning, facilitation and consensus building;
- Expertise in gender and health programming
- Demonstrated experience leading an evaluation team;
- Excellent interpersonal skills;
- Excellent skills in project management

Key Staff 2 Title: PMI/malaria technical specialist(local or international consultant)

Roles & Responsibilities: Serve as a member of the evaluation team, and provide technical expertise on malaria within the PMI guidelines

Qualifications: A minimum of five years in PMI/malaria programming, preferably in francophone Africa; excellent French communications skills

Number of consultants with this expertise needed: 1

Key Staff 3 Title: Health systems strengthening (HSS) expert (local or regional consultant)

Roles & Responsibilities: Serve as a member of the evaluation team and provide technical expertise on HSS and the six building blocks of a health system. Focus will be HSS for malaria, MCH and FP/RH services.

Qualifications: Minimum of five years' experience in health systems strengthening; demonstrated technical and programmatic knowledge of supply chain strengthening and information systems; fluent French speaker; experience in West Africa

Number of consultants with this expertise needed: 1

Key Staff 4 Title: Evaluation specialist (international, local or regional)

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance in the field on issues related to evaluation protocols, standards and implementation, including methods, development of data collection instruments, protocols for data collection, data management and data analysis.

Qualifications:

- At least five years of experience in USAID M&E procedures, project and organizational management
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience in design and implementation of evaluations

Number of consultants with this expertise needed: 1

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

- 2-3 research assistants (local) will be hired to assist with qualitative and quantitative data collection, data entry, data analyses and transcription of qualitative data.
- 1 logistics/program assistant (local) will be hired to assist the team with arrangements for transportation, lodging, venues (as needed), setting appointments and other assistance as needed.

Note: As the team is recruited, it may be possible to hire a research assistant who can provide logistic

support to the team.

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

- Yes
 No

Staffing Level of Effort (LOE) Matrix Instructions:

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

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

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

Activity / Deliverable		Evaluation/Analytic Team				
		Team Lead / HSS Specialist	PMI/Malaria Specialist	Eval Specialist	Research Assist	Research Asst/ Logistics
Number of persons →		1	1	1	2	1
1	Launch briefing	1	1	1		
2	Desk review & data synthesis	5	5	5		
3	Preparation for team convening in-country					2
4	Travel to country	2	2	2		
5	Team planning meeting	5	5	5	2	2
6	In-brief with mission	1	1	1		.5
7	Training data collectors	2	2	2	2	2
8	Prep / logistics for site visits					2
9	Data collection / site visits	12	12	12	12	12
10	Data analysis	4	4	4	2	2
11	Debrief with mission w/ presentation	2	2	2		.5
12	Incorporate mission's feedback	1	1	1		
13	Depart country	2				.5
14	Draft report(s)	8	4	6		
15	GH Pro Report QC review & formatting					
16	Submission of draft report(s) to mission					
17	USAID report review					
18	Revise report(s) per USAID comments	4		2		
	Finalization and submission of report(s)					
19	French translation of report					
20	508 compliance review					
21	Upload eval report(s) to the DEC					
Sub-Total LOE		49	39	43	18	23.5

Activity / Deliverable	Evaluation/Analytic Team				
	Team Lead / HSS Specialist	PMI/Malaria Specialist	Eval Specialist	Research Assist	Research Asst/ Logistics
Number of persons →	1	1	1	2	1
Total LOE	49	39	43	36	23.5

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

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

Travel is anticipated is anticipated to at least two departments outside of Cotonou. Site selection will be based on zones of confluence of activities and availability of comparative data for establishing trends (Borgou/Alibori and Zou/Collines are good candidates).

XIV. LOGISTICS

Note: Most evaluation/analytic teams arrange their own work space, often in their hotels. However, if facility access is preferred, GH Pro can request it. GH Pro does not provide security clearances. Our consultants can obtain **facility access** only.

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

USAID Facility Access

Specify who will require facility access:

Electronic County Clearance (ECC) (international travelers only)

XV. GH PRO ROLES AND RESPONSIBILITIES

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

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

XVI. USAID ROLES AND RESPONSIBILITIES

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

USAID Roles and Responsibilities

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

Before Field Work

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

During Field Work

- Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.
- Meeting Space. Provide guidance on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).
- Meeting Arrangements. Assist the team 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.

XVII. ANALYTIC REPORT

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

A. Evaluation Report Format

The report format should be restricted to Microsoft products and 12-point type should be used throughout the body of the report, with page margins 1" top/bottom and left/right. The report shall not exceed 30 pages, excluding references and annexes.

The format for the evaluation report is as follows:

- Executive Summary: concisely state the most salient findings, conclusions and recommendations (not more than 4 pages);
- List of acronym
- Table of Contents (1 page);
- Introduction: purpose, audience, and synopsis of task (1 page);
- Background: brief overview of the program, USAID strategies and priorities, purpose of the evaluation (2-3 pages);
- Design and Methodology: describe evaluation design methods, including constraints, limitations and gaps (1 page);
- Findings/Conclusions/Recommendations in separate sections: for each objective area (15-20 pages);
- Issues: provide a list of key technical and/or administrative issues identified (1-2 pages);
- Future Directions/Recommendations based on gaps or innovation model to be scaled up (2-3 pages);
- References (including bibliographical documentation, stakeholders meetings, key informant interviews and focus group discussions);
- Annexes, which should include:
 - The Evaluation Scope of Work
 - Any “statements of differences” regarding significant unresolved difference of opinion by funders, implementers, and/or members of the evaluation team
 - Evaluation design methods and all tools used in conducting the evaluation, such as questionnaires, checklists, survey instruments, and discussion guides
 - Sources of information, properly identified and listed
 - Biographical information on each of the team members
 - Disclosure of conflicts of interest forms for all evaluation team members, either attesting to a lack of conflict of interest or describing existing conflict of interest.

B. Evaluation Report Contents

The evaluation report should represent a thoughtful, well-researched and well organized effort to objectively evaluate what worked in the project, what did not, and why.

- Evaluation reports shall address all evaluation questions included in the scope of work.
- The evaluation report should include the scope of work as an annex. All modifications to the scope of work, whether in technical requirements, evaluation questions, evaluation team composition, methodology or timeline need to be agreed upon in writing by the technical officer.
- Evaluation methodology shall be explained in detail and all tools used in conducting the evaluation such as questionnaires, checklists and discussion guides will be included in an Annex in the final report.
- Limitations to the evaluation will be disclosed in the report, with particular attention to the limitations associated with the evaluation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Findings should be specific, concise and supported by strong quantitative or qualitative evidence.
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical and specific, with defined responsibility

for the action.

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

XVIII. USAID CONTACT PERSON

	Primary Contact	Alternate Contact 1	Alternate Contact 2
Name:	Harriet Ahokpossi	Michelle Kouletio	Carrie Rasmussen
Title:	Program Management Specialist	USAID PMI Advisor	Health Team Leader
USAID Office/Mission	USAID/Benin	USAID/Benin	USAID/Benin
Email:	hahokpossi@usaid.gov	mkouletio@usaid.gov	crasmussen@usaid.gov
Cell Phone (optional)	-	97974778	-

XIX. REFERENCE MATERIALS

Documents and materials needed and/or useful for consultant assignment, that are not listed above
All project documents and reference materials are in a shared Google folder
<https://drive.google.com/a/usaid.gov/?tab=mo#folders/0B0SqtxfW9bGEN1ZtbG1RbExsY0k>

ANNEX II. PERSONS INTERVIEWED

USAID/Benin

Kevin Armstrong, Mission Director
Carrie Rasmussen, Health Office Director
Harriet Ahokossi, Health Program Manager
Michelle Kouletio, USAID PMI Advisor
Ricardo Missihoun, Commodities & Logistic Specialist
Rose Anagonon, Administrative Assistant
Omonyélé Adjognon, Grant Management Specialist
Marie-Noël Maffon, Program and Communications Specialist
Peter Thomas, CDC Resident Advisor
Michael Humes, MCH/Malaria Advisor, AFR/SD

ARM3

Gilbert Andrianandrasana, Chief of Party
Jean Fortuné Dagnon, M&E Manager
Jeanne Togbenou, BCC Manager
Inoussa Akadiri, Case Management Manager
Urbain Amegbedji
Ramani Saliou, Diagnostics Coordinator
Lorens Zinsalo, M&E Assistant
Prudent Assogba, Field Supply Management Coordinator
Ghislaine Djidjoho, Pharmacist, Supply Chain Management

ANCRE

Mathias Yameogo, Chief of Party
Marie-Agnes Agboton-Zoumenou, Policy and Advocacy Advisor
Marthe Agbogbe Akogbeto, MNCH Advisor
Mahefa Rajoelison, Private Sector Advisor
Alphonse Guedeme, M&E Advisor

PSI/ABMS

Margaret Wilson, Executive Director
Evariste Zingan, Deputy Director, Operations
Felix Agbakou, Admin/Finance Director
Aristide Hontonou, Coordinator, Qualitative Research
Jules Hountondgi, Coordinator, Child Survival

ProFam Clinics

Rafiou Baguidi, Clinique Baguidi “L’As de cœur,” Parakou
Lahanatou Bio Mama, Clinique Beau Bébé, Parakou
Alexis Gbaguidi, Clinique Cooperative d’Abomey
Pascal Deffodji, Clinique ProFam, Savalou

Advancing Partners & Communities

Jean Affo, Country Project Coordinator

Health Finance & Governance

Pascal Soglohoun, Coordinator

Leadership, Management & Governance

Gilles Bokpe, Country Project Manager

Léandre Sohounde, M&E Advisor

Ministry of Health

National Level

Lucien Toko, Deputy Director, National Directorate of Public Health

Thierry Tossou, Deputy Director, Directorate of Maternal-Child Health

Mariam Oké Sopoh, Coordinator, National Malaria Control Program

Eric Yves Denon, National Malaria Control Program

Filémon Tokponnon, National Malaria Control Program

Bella Dos Santos-Hounkpe, National Malaria Control Program

Lamine Adognon Gtabi, National Malaria Control Program

Cherifatou Adjibabi, National Malaria Control Program

Christine Goajo, National Malaria Control Program

Boniface Denakpo, National Malaria Control Program

Department of Borgou/Alibori

Fatioulaye Issa Djibril, Director of Health, Department of Borgou/Alibori

Fabien N'tia, Chief, MCH, Department of Borgou/Alibori

Abdou Hakim GOUDA, Section Health, SPIRS, Department of Borgou/Alibori

Sister Mireille Aguessi, Hospital Director, l'Hôpital Saint Martin de Papané (Hôpital de Zone, Tcharourou)

Abdou Moumouni Bah l'Imam. Hospital Administrator, l'Hôpital Saint Martin de Papané (health zone Tcharourou)

Emile Kouthon, Obstetrician/Gynecologist, l'Hôpital Saint Martin de Papané (health zone Tcharourou)

Lydie Dedewanou, District Medical Officer, Health Center I, Tchaourou

Benoît Godonou, Nurse In-Charge, Health Center I, Tchaourou

Matinou Mama, Statistician, Health Center I, Tchaourou

Sidonie Alla, Registered Midwife, Health Center I, Tchaourou

Joel M. Lokoklounon, Manager, Health Center II, Tchatchou

Department of Atacora/Donga

Jacob Namboni, Director of Health, Department of Atagora/Donga

Jean N'tcha, Chief, MCH, Department of Atagora/Donga

Chastine Chabi, Manager, HIV/AIDS Prevention & Treatment Center, Department of Atagora/Donga

Mamodou Bio Mande, BCC Manager, HIV/AIDS Prevention & Treatment Center, Department of Atagora/Donga, Bienvenu Doho Dehogbe, National Malaria Control Program

Magloire Houeho, Acting Chief, CAME, Atacora
Parfait Koriko, Warehouse Manager, CAME, Atacora
Edwige Zinzindohoue, Nurse, CS 2 Djougou
Fati Boni Biao, Registered Midwife, CS 2 Djougou
Victoire Tchetou, Registered Midwife, CS 1 Copargo
Samuel Dagbenon, Registered Nurse, CS 2 Manigri
Emma Mensah, Registered Midwife, CS 2 Manigri
Joseph Tchanati, Nurse, CS 2 Badjoudè
Lucie Makataoue, Nurses Aide, CS 2 Badjoudè
Marie Noelle Legba, Registered Midwife, CS2 Pabégou
Anne Wele, Registered Nurse, CS 2 Pénéssoulou
Atibatou Soumanou, Nurses Aide, CS 2 Pénéssoulou
Lambert Loko, Director, Zonal Hospital, Bassila
Pérec Gandaho, General Medicine, Zonal Hospital, Bassila
Urbain Boko Y, Nurse Specialist, Zonal Hospital, Bassila
Benjamin Hounnibode, Zonal Hospital, Bassila
Modeste Houemenou, General Medicine, CS I Bassila
Vicencia Yamongbe, Registered Midwife, CS I Bassila
Sourakatou Salifou, Zonal Medical Coordinator, Djougou, Copargo, Ouaké
Bachirou Balawe, Zonal Warehouse Manager, Djougou, Copargo, Ouaké
Aboubakar Issou, Zonal Warehouse Stock Keeper, Djougou, Copargo, Ouaké
Romeo Sogan, Djougou, Copargo, Ouaké

Department of Zou/Collines

François Kossouho, Director of Health, Department of Zou/Collines
Evariste Djossou, Registered Nurse, Health Center I, Zagnanado
Estelle Azon, Registered Midwife, Health Center I, Zagnanado
Ginette Fernando, Registered Midwife, Health Center II, Agonlin Houégbo
Bertille Yevide, Nurse, Health Center II, Agonlin Houégbo
Josiane Hounhinto, Dispensary In-Charge, Health Center II, Ouinhi
Justine Kinha, Maternity In-Charge, Health Center II, Ouinhi
Romuald Sokadjo, Chief of Administration, Zonal Hospital, Cové
Anagonou Assogba, General Nurse Statistician, Zonal Hospital, Cové
Louis Lokossi, Pharmacy Manager, Zonal Hospital, Cové

Dedras NGO

Raoul Balogoun, Project Director
Zull-Kiff, Project Manager, PIHI-C, Bassila
Fortuné A. Challa, Project Manager, PIHI-C, Kandi

Sian'son NGO

Salomon Balogoun, Executive Director
Kalid Biga, Project Manager, PIHI-C, Dgougou
Hubert Torou, M&E Officer, PIHI-C, Tchaourou
Halima Coulibaly, Project Manager, PIHI-C, Tchaourou

UNICEF

Adama Ouedraogo, Section Head, Child Survival and Development

UNFPA

Koudaogo Ouedraogo, Resident Representative

WHO

Télesphore Houansou Npo

Dina Vladimirovna Gbenou

Focus Group Participants (identities kept confidential)

5 clients at CS 1 Zagnanado

22 clients at CS 1 Copargo

11 clients at CS 2 Manigri

ANNEX III. DATA COLLECTION INSTRUMENTS

EVALUATION DE LA PERFORMANCE DU PROGRAMME INTEGRE DE SANTE FAMILIALE ET DE LUTTE CONTRE LE PALUDISME DE L'USAID / BENIN

Introduction: Nous procédons à une évaluation de l'aide fournie par le gouvernement des Etats-Unis (USG) pour la santé familiale et des services paludisme au Bénin. Nous vous serions reconnaissants si vous souhaitez passer un peu de temps à répondre à quelques questions au sujet de votre expérience dans la prestation des services de soins de santé IFH / paludisme.

Consentement et confidentialité: Ce sondage est totalement anonyme (votre nom ne sera pas utilisé), et vous ne serez pas identifiés. Votre participation est volontaire. Vous n'avez pas à répondre à toutes les questions que vous ne souhaitez pas répondre. Vos réponses seront analysées avec beaucoup d'autres de fournisseurs de soins de santé et les patients à travers le pays pour se assurer que les ressources de USG et le partenariat avec les installations Bénin de soins de santé parvienne à ceux qui en ont besoin.

GUIDE D'ENTRETIEN POUR LES NIVEAUX DEPARTEMENTAL ET PERIPHERIQUE

1. Date of Visit / ___/ ___/ ____

2. Interviewer Name:

3. Name of the Health Facility

4. Department:

5. Commune

6 Zone sanitaire:

7 Nom du Répondant: Téléphone

8 Catégorie de Personnel de Santé [___]

1. Médecin spécialiste, 2. Médecins généralistes, 3. Chirurgien, 4. Dentiste, 5. Pharmacien, 6. Sage-Femme d'Etat spécialiste, 7. IDE Spécialiste, 8. IDE, 9. Sage-Femme d'Etat, 10. Infirmier Breveté 11. Autres

1a. Savez-vous que l'USAID appuie la Santé Familiale Intégrée?

Oui [___] (1) Non [___] (2)

Si Oui, comment percevez-vous cet appui?

PRESTATAIRES SERVICES
Centres de santé & cliniques ProFam

What are the best practices and achievement of IHFP, including factors that have contributed to these successes?

A. PERFORMANCE OF HIGH IMPACT INTERVENTIONS

1.1. Antenatal care (CPN, Paludisme de la femme enceinte, vaccination)

- 1.1.1 Quelle proportion des consultations prénatales est réalisée par du personnel qualifié?
- 1.1.2 Quelle proportion des femmes vues en CPN ont reçu trois(3) doses de SP pendant la grossesse?
- 1.1.3 Quelle proportion des femmes vues en CPN ont reçu trois(3) doses de vaccin anti tétanique pendant la grossesse?

1.2. Accouchement par du personnel qualifié

- 1.2.1. Est-ce que les salles d'accouchement des CS visités sont conformes (espace suffisant, oxygène, éclairage, aération, source de lumière, propreté, matériels de réanimation du nouveau-né, eau et solution de décontamination)?
- 1.2.2.
- 1.2.3. Quelle proportion d'accouchements réalisée avec remplissage du partogramme?
- 1.2.4. Quelle proportion d'accouchements réalisée en respectant le protocole de la GATPA (oxytocine dès la sortie du bébé, traction contrôlée du cordon, massage utérin)?

1.3. PF

1.3.1. Quelles sont les méthodes modernes de contraception offertes par le centre de santé (cocher oui ou non)

- Pilule Oui =1 [] Non =2 []
- Contraceptif injectable Oui (1) [] Non=2) []
- Condom Oui (1) [] Non=2) []
- MAMA Oui =1) [] Non=2 []
- Implant Oui (1) [] Non=2[]
- DIU Oui (1) [] Non=2 []
- Collier Oui (1) [] Non=2 []

1.4. SONU Complet

Est-ce que l'HZ visité offre le paquet SONU complet ? Oui (1) [] Non(2) []
Si non, pourquoi?

1.5. Vaccinations infantiles

Le centre de santé applique-t-il la vaccination des <1 an selon les stratégies requises suivantes

- stratégie fixe Oui (1) [], Non(2) []
- stratégie avancée, Oui (1) [Non=2) []

Si non, pourquoi?

- rattrapage des cas manqués, Oui (1) [Non=2) []

Si non, pourquoi?

1.6. Paludisme < 5ans

Est-ce que le TDR est systématisé avant tout traitement anti-palustre dans votre CS?

- Oui (1) [] Non (2) []

1.7. IRA < 5ans

Nombre de cas de pneumonies traitées chez les enfants avec un antibiotique approprié et par un personnel qualifié ou un Relais communautaire

1.8. Malnutrition (mesures préventives dans PCIME, stratégie nationale de PEC de la malnutrition aigüe)

- Avez-vous des activités de prévention de la malnutrition en direction des mères des enfants <5ans? Oui=1 [] Non=2 []
- Si non pourquoi?
- Si oui, demander le rythme et vérifier les équipements (anthropométrique « pèse bébé, pèse personne, toise, ruban etc. », audio visuels, culinaire, boîte à images, vidéo)
- L'équipe qui s'occupe de ces activités a-t-elle été formée? Oui =1 [] Non=2 []

1.9. Quels sont les principaux défis qui restent à lever avec votre expérience de mise en œuvre des interventions de santé familiale et de lutte contre le paludisme?

1.10. Comment procédez-vous pour lever ces défis?

1.11. Quelle méthode avez-vous en place pour le suivi des cibles des interventions de la mère et de l'enfant?

1.12. Est-ce que vos patients respectent les traitements et RDV de suivi?

Oui= 1 [] Non=2 []

- Si non pourquoi ?

B. MEILLEURES PRATIQUES & APPROCHES

- I.13. **Selon vous quelles sont les meilleures pratiques héritées des projets santé financés par USAID ?**
- I.14. **Quelles sont les meilleures approches novatrices apprises avec les projets santé financés par USAID?**

C. COMMUNICATION POUR LE CHANGEMENT DE COMPORTEMENT (CCC/BCC)

- I.15. **Pouvez-vous nous résumer le volet CCC des interventions de l'USAID?**
- I.16. **Selon vos commentaires, Pouvez-vous nous citer quelques-unes des activités de ce volet?**
- I.17. **Quelles sont les activités CCC que vous considérez comme une réussies?**
- I.18. **Que souhaiteriez-vous que l'on prenne en compte dans les futures interventions en matière de CCC?**

DDS, MCZ et/ou **RESPONSABLE DE FORMATION SANITAIRE /DEPOT/PHARMACIE**

D. HEALTH SYSTEMS STRENGTHENING AND GENDER

DI. CHAINE D'APPROVISIONNEMENT

- I.19. **Voulez-vous nous montrer les outils que vous utilisez pour gérer vos stocks de médicaments?**
- I.20. **Quel système d'alerte avez-vous en place pour prévenir les ruptures de stock des médicaments?**
- I.21. **Avez-vous enregistré une rupture de stock sur les produits suivants dans les trois (3) derniers mois:**
- I.22.
- ***Family Planning familial***
- | | | |
|---------------------------|-------------------------------------|-------------------------------------|
| • Pilule | Oui =1 [<input type="checkbox"/>] | Non =2 [<input type="checkbox"/>] |
| • Contraceptif injectable | Oui =1 [<input type="checkbox"/>] | Non =2 [<input type="checkbox"/>] |
| • Condom | Oui =1 [<input type="checkbox"/>] | Non =2 [<input type="checkbox"/>] |
| • Implant | Oui =1 [<input type="checkbox"/>] | Non =2 [<input type="checkbox"/>] |

- DIU Oui =1 [] Non =2 []

- **Maternal Health**

- SP Oui =1 [] Non =2 []
- Fer – Acide Folique Oui =1 [] Non =2 []
- Oxytocin Oui =1 [] Non =2 []
- misoprostol Oui =1 [] Non =2 []
- Vaccin antitétanique Oui =1 [] Non =2 []

- **Paludisme**

- TDRs Oui =1 [] Non =2 []
- CTAs Oui =1 [] Non =2 []
- MILDS Oui =1 [] Non =2 []

- **Child Health**

- Orasel/Zinc Oui =1 [] Non =2 []
- Vaccin antirouge Oui =1 [] Non =2 []
- Antibiotics Oui =1 [] Non =2 []

- **Infection Prevention**

- Gants d'examen Oui =1 [] Non =2 []
- Eau de javel Oui =1 [] Non =2 []
- Boîtes de sécurité Oui =1 [] Non =2 []
- Autoclave ou Poupinel Oui =1 [] Non =2 []

4) Que faites-vous en cas de rupture de stock ?

5) Le responsable de la gestion des stocks a-t-il été formé sur les nouveaux outils de gestion des stocks?

Oui=1 [] Non=2 []

6) Comment vous débarrassez-vous des médicaments périmés ?

D2. Health Management Information System

Niveau périphérique

1.23. **Quelle(s) difficulté(s) éprouvez-vous à l'utilisation du système de collecte et de gestion de l'information sanitaire?**

1.24. **Selon quel rythme acheminez-vous les rapports statistiques et d'activités?**

D3. RESSOURCES HUMAINES EN SANTE

I.25. Indiquez le nombre d'agents présents sur les postes suivants:

Les normes d'effectifs des ressources humaines en santé et les nombres actuelles

Personnel par catégorie professionnelle	CS Arrond (2)		CS Commune (1)		Hosp Zone		Centre Hosp Département	
	Normes d'effectifs	Actuelles	Normes d'effectifs	Actuelles	Normes d'effectifs	Actuelles	Normes d'effectifs	Actuelles
Médecins Spécialistes	0		2		8		29	
Médecins Généralistes	0		1		6		6	
Chirurgiens Dentistes	0		0		1		2	
Pharmacien	0		0				1	
Sage Femme d'Etat spécialistes	0		2		3		4	
Infirmiere d'Etat spécialistes	0		3		14		23	
Infirmiere d'Etat	1		2		10		12	
Sage Femme d'Etat	1		2		8		0	
Infirmiere Breveté	4		3		10		4	
Ing./Tech.Sup/Tech.B Analyses Biomédicales	0		3		7		14	
Ing./Tech Sup en Imagerie Médicale	0		1		4		4	
Aide-soignants	4		6		20		6	
Technicien ou assistant d'hygiène	1		1		2		2	
Tech. Sup Action Sociale & Prothésistes Dentaires	0		1		4		3	
Personnel Administratif	5		9		35		31	
EFFECTIF de personnel par structure sanitaire	16		36		132		92	
Nombre de Formations Sanitaires publiques à couvrir dans le pays	578		82		34		1	

I.26. Quel est le nombre de personnel féminin dans équipe?

I.27. Quel est le nombre de staff qui lors des deux dernières années a bénéficié des formation/recyclage sur les thèmes suivants:

Cadre	Paludisme		PMCI		Santé Maternelle		Planning Familial		RSS	
	PC Nouveau Protocol	Prevention	Diarrhea	IRA	CPN	GATPA	Conseil	l'Offre	GCA	SNIGS
Médecins Spécialistes										
Médecins Généralistes										
Pharmacien										
Sage-Femme d'Etat spécialistes										
Infirmiere d'Etat spécialistes										
Infirmiere d'Etat										
Sage-Femme d'Etat										
Infirmiere Breveté										
Ing./Tech.Sup/Tech.B Analyses Biomédicales										
Ing./Tech Sup en Imagerie Médicale										
Aide-soignants										
Technicien ou assistant d'hygiène										
Personnel Administratif										
COGES										
Relais										

D4. FINANCEMENT DE LA SANTE

1.28. **Quelle est la source de dépenses familiales en matière de santé? (Budget familial; mutuelle de santé Assurance, Sécurité Sociale)**

D5. MEILLEURES PRATIQUES & APPROCHES

1.29. **Selon vous quelles sont les meilleures pratiques héritées des projets santé financés par USAID?**

1.30. **Quelles sont les meilleures approches novatrices apprises avec les projets santé financés par USAID?**

2. NIVEAU DDS/ZS/RESPONSABLES SANTE FAMILIALE

Quels sont les obstacles rencontrés et les limites la mise en œuvre des projets de santé familiale intégrée y compris les facteurs qui ont contribué à leurs insuffisances?

2.1 Obstacles et Limites

2.1.1 Quelles sont les conséquences du fractionnement des projets de l'USAID avec des financements émiettés, prédéterminés et fixes (niveau central)?

2.1.2 Que vous suggère l'expression « Effet projet » (général)

2.1.3 Si son effet est négatif, que proposez-vous pour l'éviter dans le futur?

2.1.4. Dans les projets de l'USAID, que pensez-vous que nous devons faire pour privilégier le “faire faire” au “faire” afin de faciliter l'appropriation/capitalisation des acquis du projet (niveau central)?

2.1.5. Comment rationaliser l'utilisation des ressources humaines, financières et techniques, mis à disposition par les projets?

2.1.6. Le défaut d'intégration du secteur privé (niveau central)

2.1.7. Que pensez-vous de l'affirmation suivante:

« Les prestataires et le système sanitaire ne sont pas souvent bien préparés pour accueillir et assurer les nouvelles stratégies expérimentées par les projets » (périphérie)

2.1.8. Pensez-vous que les actions/activités, procédures, stratégies, systèmes de collecte et de gestion de l'information sanitaire, outils, voire perdiems se déroulent de façon harmonieuse entre les divers partenaires?

2.1.9. Quelles sont selon vous les conséquences sur l'offre des soins et les interventions des projets, attribuables aux grèves persistantes?

2.1.10. Avez-vous noté des difficultés de collaboration sur les projets financés par l'USAID (niveau central DDS et ZS)

Oui=1 []

non=2 []

Si oui, les quelles ?

2.1.11. Quelles solutions suggérez-vous pour résoudre ces difficultés?

3.1.2. Selon vous quels ont été les défis? (PNLP, ARM3, DDS, ZS)

3.1.3. Quels sont les facteurs qui ont contribué aux succès et/ou aux échecs de ARM3? Justifiez vos réponses (PNLP, ARM3, DDS, ZS)

3.1.4. Quelles interventions jugez-vous indispensables dans le prochain projet ARM3-2? Justifiez vos choix (PNLP, ARM3, DDS, ZS)

3.2. Suggestions & Recommandations

3.2.1. Que proposez-vous pour que ARM3 atteigne ses objectifs pour le temps qu'il lui reste?

PNLP

ARM3

IFHP

DDS / ZS

3.2.2. Quelles sont les leçons que vous tirez de la mise en œuvre de ARM3 depuis son démarrage?

PNLP

ARM3

IFHP

DDS / ZS

EVALUATION DE LA PERFORMANCE DU PROGRAMME INTEGRE DE SANTE FAMILIALE ET DE LUTTE CONTRE LE PALUDISME DE L'USAID / BENIN

Introduction: We are conducting an evaluation of assistance provided by the United States Government (USG) for Family Health and Malaria services in Benin. We would be grateful if you would spend a short time answering a few questions about your experience providing IFH/Malaria health care services.

Consent and Confidentiality: This survey is completely anonymous (your name will not be used), and you will not be identified. Your participation is voluntary. You do not have to answer any questions that you don't want to answer. Your responses will be analyzed along with many others from health care providers and patients across the country to assure that the U.S. resources and the partnership with Benin health care facilities reaches those in need.

GUIDE D'ENTRETIEN POUR LES ORGANISATIONS NON-GOVERNEMENTALES (ONG)

1. Date de la visite ___/___/___
2. Nom de l'enquêteur _____
3. Nom de l'ONG _____
4. Department: _____
5. Zone: _____
6. Nom du Répondant: n^o de tél _____
7. Profil du répondant _____

1. Comment appréciez-vous la collaboration entre ARM3 et votre ONG?
2. Y a-t-il eu des problèmes/obstacles ? [] oui=1 [] non=2
 - 2.1. Si oui lesquels?
 - 2.2. Comment ont-ils été résolus ?
3. Comment appréciez-vous l'appui de vos interventions par APC?
4. Y a-t-il eu des problèmes/obstacles ? [] oui=1 [] non=2
 - 4.1. Si oui lesquels?
5. Comment appréciez-vous la collaboration entre la zone sanitaire et votre ONG?
6. Y a-t-il eu des problèmes/obstacles ? [] oui=1 [] non=2
 - 6.1. Si oui lesquels?
 - 6.2. Comment ont-ils été résolus?
7. Comment appréciez-vous la collaboration entre la communauté et votre ONG?
8. Y a-t-il eu des problèmes/obstacles? [] oui=1 [] non=2

- 8.1. Si oui lesquels?
- 8.2. Comment ont-ils été résolus?
9. De quelle manière USAID renforce-t-elle la collaboration entre ceux qui sont chargés de la Mise en Œuvre des activités PIHI à la base communautaire?
10. Quelle(s) difficulté(s) éprouvez-vous à l'utilisation du système de collecte et de gestion de l'information sanitaire?
11. Selon quel rythme acheminez-vous les rapports statistiques et d'activités ?
12. Quelle(s) difficulté(s) éprouvez-vous avec la chaîne d'approvisionnement des intrants y compris les MILD?
13. Quel est l'effectif de votre personnel ? /___/___/
14. Enumérer les différentes catégories de personnel
15. Quel est le % du personnel féminin dans l'équipe?
16. Pensez-vous que les actions/activités, procédures, stratégies, systèmes de collecte et de gestion de l'information sanitaire, outils, voire per diems se déroulent de façon harmonieuse entre les divers partenaires?
17. Quels sont les principaux défis qui restent à lever avec votre expérience de mise en œuvre des interventions de lutte contre le paludisme (comme Prévention, Prise en charge, Approvisionnement en médicament, référence des cas graves)?
- 17.1. Comment procédez-vous pour lever ces défis?
18. Quels sont les principaux défis qui restent à lever avec votre expérience de mise en œuvre des interventions de santé familiale (comme PF, VIH/SIDA, PTME, etc...)
- 18.1. Comment procédez-vous pour lever ces défis?
19. Quelle méthode avez-vous en place pour le suivi des cibles des interventions de la mère et de l'enfant?
20. Avez-vous enregistré une rupture de stock de vos produits dans les trois (3) derniers mois:
 oui=1 non=2
- 20.1 Si oui, quels produits?
- 20.2. Comment a-t-elles été résolus?
21. Paludisme < 5ans
- Est-ce que le TDR est systématisé avant tout traitement anti-palustre?
- oui=1 non=2
22. IRA < 5ans
- Combien de cas de pneumonie chez l'enfant ont été traités avec les antibiotiques appropriés par des agents de santé formés ou par des agents de santé communautaire dans le cadre des programmes financés par l'USAID? /___/___/

23. Quelles sont les mesures préventives dans PIHI de la malnutrition aigüe sur lesquelles votre ONG intervient?

24. Avez-vous des activités de prévention de la malnutrition en direction des mères d'enfants <5ans ? oui=1 non=2

24.1. Si oui lesquelles?

24.2 Si non pourquoi?

25. Quelles sont les leçons que vous tirez de la mise en œuvre des activités PIHI à base communautaire?

26. Quelles recommandations avez-vous pour le programme futur de l'USAID en matière de la santé communautaire?

Guide de Groupe de Discussion Focalisée

Participants:

Note: L'animateur doit ventiler participants par sexe et par âge après organisée les groups pour la discussion focalisée.

Zone: _____ **Commune:** _____

Communautés: _____

Date:

Questions de discussion pour des groupes de 8 à 12 clients du Centre de Santé : L'équipe d'enquête devrait assurer participants aux groupes de discussion qu'ils ne seront pas identifiés dans un rapport et que leur expérience est une rétroaction importante pour assurer des services axés clients la qualité sont disponibles dans leurs propres communautés et à travers le pays.

Introduction: «Je tiens à vous remercier d'avoir accepté de participer à ce groupe de discussion importante. Commençons par nous présenter en utilisant nos prénoms. Lorsque nous aurons terminé ce tour d'introductions Je vais demander au groupe quelques questions. Vous aurez tous l'occasion de parler. Vous n'êtes pas obligé de répondre à chaque question ».

Q1. Comment avez-vous bénéficié des services de santé familiale et/ou du paludisme au centre de santé _____?

Probe : Avez-vous tous été en mesure d'obtenir des services?

Probe : Y at-il d'autres avantages qui sont fournis?

Q2. Y at-il des difficultés ou des obstacles à l'utilisation des services de santé familiale, le paludisme ou des autres services? Parlez-nous en .

Probe : Problèmes avec la prestation de services ?

Probe : Coûts ? Temps / distance de venir à l'établissement de santé ?

Probe : Ces difficultés commun? Avez-vous tous connu ces difficultés ou des difficultés similaires ?

Probe : Y at-il d'autres difficultés ou défis ?

Q3. Avez-vous remarqué des changements dans les services de santé familiale et le paludisme au cours des deux dernières années? Si oui, se il vous plaît nous dire à propos de ces changements.

Probe: Pourquoi et quand ces changements ont eu lieu?

Q4. Les communautés ont été impliquées dans la gestion ou de l'organisation des services de soins et de soutien?

Probe: Faites les Communautés ont une voix dans les services de la façon dont sont fonctionner?

Q5. Comment avez-vous été informé des services offerts par le centre de santé?

Probe: [Radio, Télévision, Voisin, Parent, Agent de santé, Relais communautaire, Conjoint, COGECS, Autres]

Q6. Quand vous étiez avec l'agent de santé, vous a-t-il mis à l'aise pour recevoir la prestation? qu'a-t-il fait en particulier?

Probe: [reçu seule, a bien accueilli, a posé des questions, a rassuré de la confidentialité des discussions, a rassuré de la disponibilité des produits (Par exemple, contraceptifs), autre]

Probe: Etiez-vous à l'aise pour poser des questions à l'agent de santé lors de la séance?

Q7. Quelle appréciation faites-vous du temps d'attente la denier consultation?

Probe: temps de arrive, temps de départ

Q8. Combien avez-vous dépensé habituellement les prestation au centre de santé?

Probe: Pour le transport, la consultation, les médicaments et / ou la méthode contraceptive choisie, autre?

PORTOFOLIO/PROGRAMME PERFORMANCE EVALUATION

INTERVIEW GUIDELINE FOR MANAGERS (USAID-PMI Advisor /COP ARM3/COP ANCRE-MOH UNICEF WHO UNFPA CTB)

Veillez informer l'interviewé que la discussion concerne l'ensemble des Opérations de l'USAID (USAID/Portfolio en l'occurrence les projets : IFHP =>ANCRE, ARM3, LMG, PIHI etc).

Il est demandé à l'interviewé de bien vouloir indiquer/spécifier le(s)quel(s) des projets le concerne.
1^{ère} partie est générale du portfolio et la seconde partie sera plus spécifique

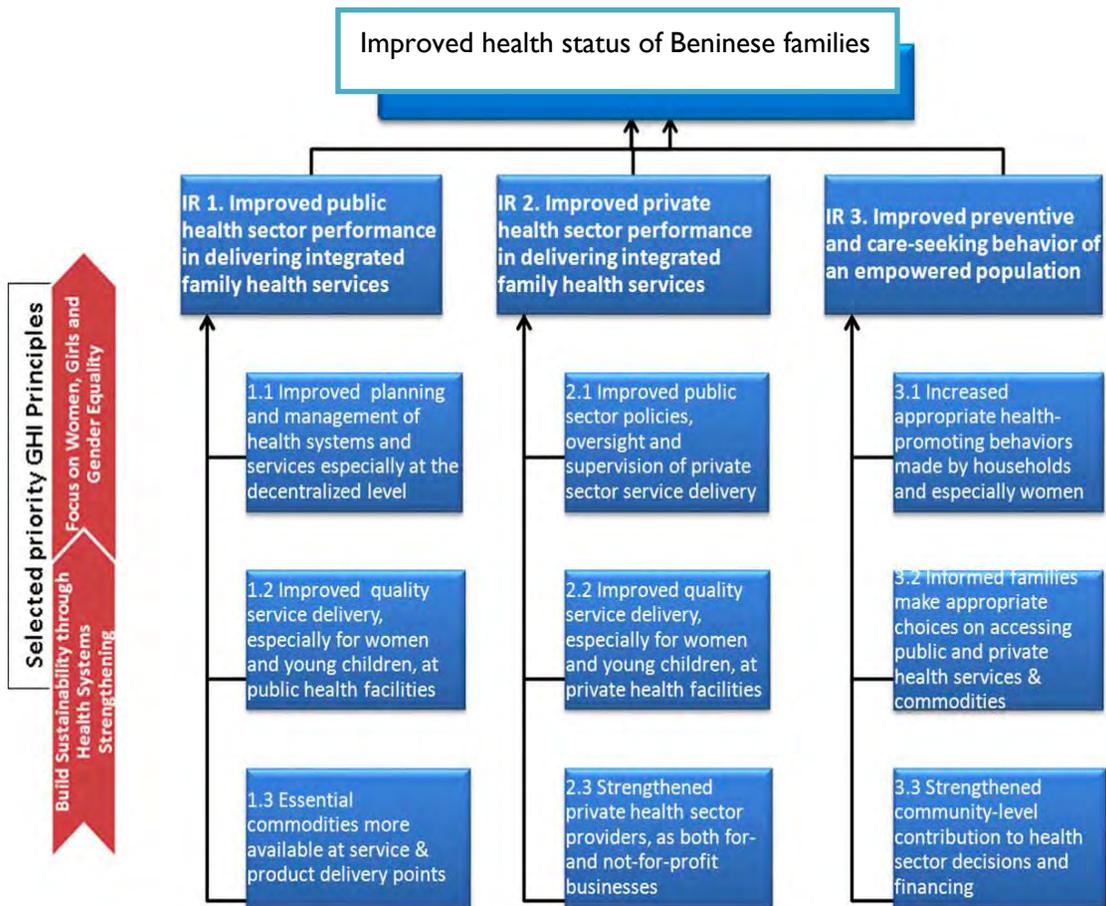
1. Date de l'interview :	
2. Interviewer :	
3. Nom et Fonctions de la (ou des) personne (s) interviewée(s):	
4. Quelle est la mission de votre institution en matière de Integrated Family Health Program (IFHP) including : MCH, RH, FP, la lutte contre le Paludisme, Leadership and gouvernance. et Paquet Intégré d'intervention à Haut Impact (PIHI), Health Financing (HF), Social marketing and private sector? ... etc.	
5. Dans le cadre de la réduction de la morbidité et mortalité (OMD 4&5) Comment collaborez-vous avec le MS : la Direction de la Santé Mère & Enfant (DSME), le Programme Elargi de vaccination (PEV), le Programme National de Lutte contre le Paludisme (PNLP), etc.?	
6. Quels sont les documents normatifs (politique, base line documents) qui ont été financés/élaborés par votre institution dans le cadre de l'appui au MS?	
7. Quels sont selon vous les documents normatifs qui manquent encore au pays?	
8. Quelles études ont été réalisées dans le pays au cours des 5 dernières années en lien avec le soutien de votre institution au secteur de la santé? NB : Demander les rapports des études qui ont été réalisées.	
9. Votre institution appuie-t-elle des interventions directes au niveau opérationnel?	
10. Quels sont selon vous les bienfaits de l'intégration des activités (SME/SR/PF PEV, Lutte contre le Palu, Nutrition, WASH, etc.) des Programmes dans la réduction de la mortalité– Morbidité des groupes cibles? Le cas échéant, ces bienfaits ont-ils été documentés?	
11. Quels sont les effets pervers des programmes financés dans le domaine de la santé?	
12. Quelles leçons tirez-vous de la mise en œuvre de ces interventions?	
13. Quelles sont selon vous, les activités relatives à la santé Mère Enfant/SR /PF PEV et Lutte contre le Palu et Nutrition WASH qui doivent nécessairement figurer dans les programmes futurs?	

<p>14. Quelles sont, selon vous les lacunes qui restent à combler en matière d'appui au secteur sanitaire à titre indicatif:</p> <p>En matière de documents normatifs:</p> <p>En matière de capacités de mise en œuvre:</p> <p>En matière de niveau de couverture des bénéficiaires:</p> <p>En matière de gestion des risques liés à l'activité:</p> <p>En matière de SME/SR/PF PEV:</p> <p>En matière de Lutte contre la Paludisme:</p> <p>En matière de : Nutrition WASH:</p>
<p>15. Existe-t-il dans le pays des exemples d'initiatives de SME/SR/PF-PEV Lutte contre le Paludisme/Nutrition /WASH réalisées par d'autres partenaires qui pourraient inspirer vos appuis futurs?</p>
<p>16. Comment, selon vous, peut-on améliorer la collaboration entre votre Institution et les autres partenaires qui interviennent dans la santé?</p>
<p>17. Dans quelle mesure le projet ARM3 a contribué à la couverture et la performance des interventions antipaludiques au Bénin?</p>
<p>18. Quelles sont les meilleures/bonnes pratiques et réalisations de ARM3, y compris les facteurs qui ont contribué à ces succès? (I srt Question of Evaluation)</p>
<p>19. USAID/Bénin a besoin de savoir dans quelle mesure ses efforts de renforcement des systèmes de santé (RHS, SGIS, chaîne d'approvisionnement / produits de base, financement des soins de santé et la gouvernance) et genre aux niveaux central, intermédiaire et périphérique (établissements et de la communauté) contribuent à la performance.</p>
<p>20. Peut-on examiner les résultats des activités à la fois pour les secteurs public et privé en matière IFHP & ARM3 et faire des recommandations sur les endroits où la mission USAID/Benin devrait concentrer ses efforts HSS et de genre à l'avenir?</p>
<p>21. Quels ont été les obstacles rencontrés et les limites du IHFP, ARM3 y compris les facteurs qui ont contribué à ces lacunes?</p>
<p>22. Selon vous,</p> <p>a) quel(s) projet(s) peuvent être jugés de successful?</p> <p>b) lesquels peuvent être jugés de moins satisfaisant?</p>

Health Facilities and NGOs Sampled

Department	Health Zone	Health Center 1	Health Center 2	ProFam	NGO	TOTAL
Donga			Djougou			8
			Pabegou			
		Copargo	Badjoude			
			Penessulu			
	Basilla	Basilla	Manigri			
Collines				Bon Secur (Savalou)		1
Zou	Cové	Ouinhi				5
		Zagnanado	Agonlin H	Clin Coop (Abomey)		
Borgou	Papane	Tchaourou	Tchatchou	Clin Beau Bebe Clin Baguidi (Parakou)	Dedras Sian'son	7
TOTAL	3	5	7	4	3	21

ANNEX IV. USAID/BENIN IFHP RESULTS FRAMEWORK



ANNEX V. MAP OF BENIN



ANNEX VI. GENERAL PIHI STATUS IN SAMPLED FACILITIES

GENERAL STATUS OF PIHI IN SITES VISITED

Since USAID has not actively supported MCH-FP services for more than two years, this information is for reference only and is not intended to reflect on IFHP.

Maternal Health

- 83 percent of antenatal care (ANC) clients were seen by qualified health personnel.
- 67 percent of ANC clients received at least two IPT doses of SP. In January 2015 the national policy was changed to three doses for all pregnant women; however, many providers interviewed are not aware of the policy change and think that only women who are HIV-positive are supposed to get three doses of SP.
- 56 percent of ANC clients received at least two doses of tetanus toxoid. Many women do not seek antenatal care during the first trimester of their pregnancy and therefore cannot receive three doses of tetanus toxoid according to the immunization schedule.
- Partogram is used in 81 percent of cases of labor.
- AMTSL is practiced in 82 percent of deliveries. While its use is widely reported among the providers interviewed, consistency of use varies, with one site reporting that AMTSL is used in only 31 percent of deliveries. There are various reasons for lack of AMTSL use—and other best practices—but lack of trained personnel or transfer of trained personnel to another facility are commonly cited explanations.
- At the facilities visited, 56 percent of the maternity units do not meet national standards. Many delivery rooms are run-down, poorly lit or ventilated and poorly maintained. There are a few exceptions, such as the delivery room at the health center at Ouinhi (pictured below), which was renovated and equipped with support from the Belgium Technical Cooperation.
- EmOC is not available at the government health centers visited due to lack of trained staff and equipment. Two of the four ProFam clinics visited can provide Basic EmOC. Complete EmOC is available at two of the three zonal hospitals visited. The zonal hospital at Tchaourou does not have equipment or personnel with the requisite knowledge and skills.



Newborn and Child Health

- In public health facilities visited, health personnel reported that several strategies are used for childhood immunization:
 - 82 percent use fixed (facility-based) immunization services
 - 67 percent conduct outreach immunization services
 - 24 percent conduct mop-up services
- Reported rates of immunization coverage vary widely:

	2012 DHS	2013 MOH	2015 MICS
BCG	88	112.6	89.4
Measles	70	96	65.1
Penta 3	74	101	71

The data shown in the table above for the coverage rates of three selected vaccines indicate that the differences between the two population-based surveys (DHS (2012) and MICS (2015)) are not significant. However, when these statistics from DHS and MICS are compared with the EPI data from the MOH for 2013, there is significant difference. DHS and MICS are population-based surveys, while the MOH statistics are produced at the service-delivery level and, therefore, are more susceptible to error. This wide variation between the MOH coverage results and that of the DHS and MICS warrants more thorough investigation in order to strengthen the MOH data collection and registering procedures.

- Only one of the four ProFam clinics visited provides child immunizations when a child is brought in for services. The other ProFam clinics do not offer childhood immunizations,

and they may refer clients to public health facilities (but no evidence for this was provided).

- For diagnosis and treatment of malaria for children less than 5 years of age, health personnel report that use of RDT and treatment with ACT is systematic. However, 11 percent of sites visited reported having had stock-outs in the past three months of RDTs and 33 percent reported stock-outs of ACTs.
- The CHWs also use RDTs and ACTs, although two of the NGOs managing community PIHI activities reported that some CHWs did not have stocks of RDTs and/or ACTs for three months.
- Health personnel interviewed reported that 41 percent of children with pneumonia are treated with an appropriate antibiotic. Fifty-nine percent of health units visited had stock-outs of antibiotics in the past three months. In the Kandi Health Zone, 53 out of 388 (13.6 percent) children with an ARI were treated with antibiotics by CHWs.
- For prevention and treatment of malnutrition, 78 percent of facilities report conducting activities, primarily counseling and health education, for malnutrition prevention; 39 percent have a schedule for nutrition activities. Fifty-six percent of the health personnel interviewed report having been trained in prevention or treatment of malnutrition. Service providers report that all mothers are counseled about exclusive breastfeeding and infant and young child feeding (IYCF). Many health personnel interviewed said there are increasing numbers of malnourished children although no data were provided to substantiate those statements. However, DHS and MICS data show suboptimal feeding practices are common.

Family Planning

- Most of the MOH health facilities visited by the team reported to offer a wide range of reversible contraceptive methods, including natural methods, and short- and long-acting methods. Eighty-nine percent of facilities reported currently having all methods in stock. In MOH health centers, FP services are provided in the maternity unit but not the dispensary. If the midwives are busy with ANC consultations or a delivery, FP clients have to wait, are told to return another time or are referred elsewhere.
- Several health facilities run by faith-based organizations have agreements that allow the MOH to designate the facilities as public. For example, the Hospital Saint Martin of Papané in Tchaourou is designated as the MOH zonal hospital and offers services stipulated for a zonal hospital. As a Catholic-owned facility, however, it provides only natural FP methods. Clients who get other health care at the hospital have to go elsewhere for other FP methods.
- Despite the wide availability of FP services, the CPR at facilities visited where rapid estimation was possible ranged from three to seven percent, well below the national average of 7.9 percent (DHS 2012).
- The wall chart “Do You Know Your Family Planning Choices?” that is supposed to be displayed in USAID-supported sites was not available at all sites visited.
- CHWs are authorized to distribute condoms and pills. Program managers at two NGOs reported that newly recruited CHWs are not distributing these contraceptives because

they have not yet been trained for FP. The NGOs said that there were no FP trainers available at the departments or zones.

- The four ProFam clinics visited reported offering a full range of modern contraceptive methods. None of the three clinic owners know what proportion of their revenue is from FP: One manager estimated less than one percent; one manager estimated 40 percent; one manager had no idea.
- PSI/ABMS runs youth-focused programs and an information telephone help-line. These activities are funded by the Royaume des Pays Bas. The evaluation team briefly saw the help-line operation during a visit to the PSI/ABMS office in Cotonou but did not visit the “Centres Jeune Amour et Vie.”

Behavior Change Communication

- In the health facilities visited, health personnel responded that counseling and interpersonal communication is used, particularly during antenatal care consultations and child health consultations.
- At the community level, CHWs conduct household visits to advise clients about PIHI, in particular malaria prevention and child health (diarrhea, ARI).
- Participants in three focus groups at public facilities said that their treatment by health personnel is better than it used to be. The participants said the health personnel are now more respectful and counseling is done in private.

ANNEX VII. MOH STAFF AT FACILITIES VISITED

Shaded columns indicate the number of staff by category that should be working at the various types of facilities, according to national standards. The unshaded columns show the range of staff numbers for the facilities visited. ¹⁴

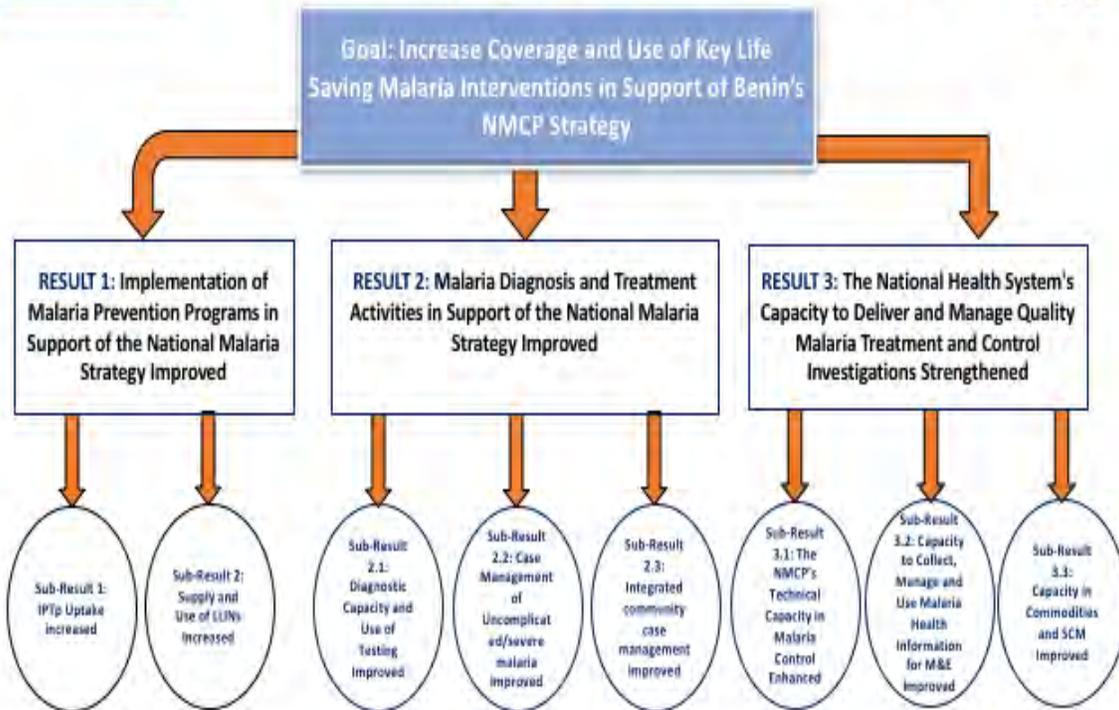
Professional category	Health Center 2		Health Center 1		Zonal Hospital	
	Standard	Actual	Standard	Actual	Standard	Actual
Médecins Spécialistes	0	0	2	0 - 1	8	0 - 2
Médecins Généralistes	0	0	1	0 - 1	6	1 - 4
Chirurgiens Dentistes	0	0	0	0	1	0
Pharmacien	0	0	0	0		0 - 3
Sage Femme d'Etat spécialistes	0	0	2	0	3	0 - 2
Infirmiere d'Etat spécialistes	0	0	3	0	14	0 - 2
Infirmiere d'Etat	1	0 - 2	2	1 - 4	10	5 - 12
Sage Femme d'Etat	1	1 - 2	2	1 - 3	8	3 - 7
Infirmiere Breveté	4	1 - 2	3	0 - 1	10	9 - 10
Ing./Tech.Sup/Tech.B Analyses Biomédicales	0	0 - 1	3	1 - 2	7	3 - 5
Ing./Tech Sup en Imagerie Médicale	0	0	1	0	4	1 - 2
Aide-soignants	4	1 - 5	6	2 - 8	20	21 - 27
Technicien ou assistant d'hygiène et agent d'entretien	1	0 - 1	1	0 - 1	2	3 - 5
Tech. Sup Action Sociale & Prothésistes Dentaires	0	0	1	0	4	0
Personnel Administratif	5	0 - 2	9	0 - 6	35	27 - 29
TOTAL	16	2 - 14	36	10 - 22	132	92 - 94

¹⁴ Ministère de la Santé. Le Plan Stratégique de Développement des Ressources Humaines du Secteur Santé, 2009-2018.

ANNEX VIII. ADDITIONAL INFORMATION FOR ARM3



ARM3 Goal, Results and Sub-Results



ARM3 COST ANALYSIS

ANALYSIS OF PROJECT COST, FINANCING PLAN AND DISBURSEMENTS

Program Cost

The initial cost of ARM3 is estimated at US \$37.098 million (Table 1a), according to the sources provided. The cost of the program is presented in terms of US dollars, while salaries of local staff and local procurement are expected to be quoted and traded in local currency (FCFA).

Although the partnership with the MOH provides a contribution in kind (inputs, offices and personnel), no quantitative estimate was available. An amount of US \$7,099,949 is noted as the cost share contribution. It is understood that the contribution of the MOH through the employees of the public and/or public convention should be taken into account in the initial and actual program cost.

Table 1A: Program Cost at Evaluation (millions US\$)

SOURCES	Appraisal Cost (Millions US\$)	TOTAL (Millions US\$)	% Sources
USAID /PMI	29.998	29.998	80.86%
Government of Benin	NA	NA	NA
Other ¹⁵	7.100	7.100	19.14%
TOTAL	37.098	37.098	100.00%

Program Actual Cost at the Time of Evaluation (March 2015)

The program cost review was done in June 2014. At the time of this evaluation, the program actual cost is estimated at US \$21,155,296, compared to the initial cost of US \$37,098 million, following a decrease (“de-scoping”) of US \$10 million (26.95 percent) by USAID. The actual amount of MDCl CA amount is US \$19,998 million. Table 1b shows the actual program cost as of March 2015.

¹⁵ Cost share contribution required

Table IB: Program Cost at Mission Date March 2015 (millions US\$)

SOURCES	Actual Cost (Millions US\$)	TOTAL (Millions US\$)	% Sources
USAID/PMI	19.998	19.998	94.53%
Government of Benin	NA	NA	NA
Other ¹⁶	1.007	1.007	4.76%
	150	150	0.71%
TOTAL	21.155	21,155	100.00%

Amounts and dates of disbursements (US\$)

Review of the ARM3 approved budget from year 1 to year 3 shows the following:

- Year 1: approved budget of \$5,842,972 versus expenditures of \$2,948,834, i.e., 49.53 percent under budget
- Year 2: approved budget of \$10,312,925 versus expenditures of \$5,787,650, i.e. 43.88 percent under budget
- Year 3: approved budget of \$7,371,097 versus expenditures of \$6,712,899, i.e., 8.93 percent under budget
- Year 4: approved budget of \$2,480,974 with expenditures of \$3,177,277, i.e., 28.07 percent over budget.

From years 1 to 3, the underspending of the budget required by the PUI is noted. The percentage of change is based on the approved work plan versus expenses, which has implications on the achievements of activities planned. For year 4, the percent change is based on the comparison of the de-scoped budget versus the year 4 approved budgets.

¹⁶ Cost share contribution required of US\$1,007 million and US\$150,000 as LLINs cost

SUMMARY OF ARM3 MAJOR CHANGES

Category	Changes
Activities & Responsibility	<p><u>Year 1:</u></p> <ul style="list-style-type: none"> - Sentinel site surveillance: Proposed methodology for contracting INRSP through MCDI was not considered appropriate by USAID procurement rules. As a result, USAID had to procure these services directly. <p><u>Year 2:</u></p> <ul style="list-style-type: none"> - In year 2, ARM3 took over the implementation of iCCM activities from the USAID-funded BASICS project and implemented an mHealth pilot project in two health zones of Bassila and Tchaorou; ARM3’s responsibility for implementing the iCCM/mHealth project ended at the end of December 2014. - Trainings on LMIS began in year 2. <p><u>Year 3/De-scoping changes to ARM3:</u></p> <ul style="list-style-type: none"> - Community BCC activities were phased out at the end of Year 3, and JHU-CCP left the ARM3 consortium at the end of June 2014; future community BCC activities will be managed through new grants with local NGOs to manage Community PIHI activities. - For years 4 and 5, MCDI has retained responsibility for providing technical assistance in the design of a malaria BCC plan/strategy for the NMCP and contributing to national malaria communications campaigns including World Malaria Day. Per the annual Malaria Operation Plan, MCDI also retained the responsibility for conducting a BCC assessment study, which will be completed in May 2015. - Effective July 2014, the authorization/responsibility for approving funding of activities, supervision and trainings at the health zone level, as well as approving agreements between health zones and hospitals, was transferred to the NMCP. - In year 3, management support, including preparation of the Integrated Annual Technical Plan and operational costs were transferred to the NMCP under a G2G agreement. - Starting in July 2014, all ARM3 activities related to the RMIS including data collection, validation and production of the quarterly surveillance bulletin were discontinued. The NMCP assumed direct responsibility for managing them under a G2G agreement. - Starting in July 2014, ARM3 was no longer responsible for strengthening the health zones’ malaria supply chain management. The NMCP will receive direct funding for this activity under the G2G mechanism in an effort to build capacity and improve sustainability. - Starting in year 3, ARM3 started to implement regional EUV surveys (as opposed to national EUV surveys conducted in year 1). <p><u>Year 4:</u></p> <ul style="list-style-type: none"> - There was reluctance from the NMCP to make changes to the IPTp protocol without review/acceptance from the academic community. WHO recommendations were initially not supported, but in the end, after a substantial delay, the protocols were approved in the first quarter of year 4. - The update of the malaria modules was delayed because the NMCP did not assign a high level of priority to the review of these documents. This resulted in the delay of the approval from year 1 to years 2 and 3.
Cost	<ul style="list-style-type: none"> - 30 million (funding reduced by 10 million to \$19,997,901 because of “de-scoping” of ARM3)
Financing Plan	<ul style="list-style-type: none"> - Activities for years 4 and 5 were prioritized following the de-scoping in year 3.

Category	Changes
Implementation Schedule	<ul style="list-style-type: none"> - Activities were either prioritized or eliminated following the de-scoping of ARM3. - iCCM implementation was initially planned for one year. Due to the de-scoping, its implementation was supposed to end at the end of June 2014. USAID subsequently approved an extension, which allowed the iCCM component to be implemented through the end of year 3 (September 2014) as originally planned.
Partners	<ul style="list-style-type: none"> - Africare and JHU-CCP left the consortium due to de-scoping.
Employees and Consultants	<ul style="list-style-type: none"> - The de-scoping of ARM3 led to the early termination of 25 staff from Africare and JHU-CCP and the scaling back of activities for years 4 and 5. - ARM3's technical coordinator left the project at the end of year 3.
Contractors & Suppliers	No changes
Local Beneficiaries	<ul style="list-style-type: none"> - 1,120,743 beneficiaries at the community level, including 211,438 children under 5, were added to the project through the addition of the iCCM component.

SELECTED ARM3 ACTIVITIES AND OUTPUTS TO DATE, ORGANIZED ACCORDING TO THREE RESULTS:

1. Capacity building of malaria prevention programs for increased uptake of IPTp and increased supply and use of LLINs:

- Normative documents on IPTp (policy, strategy, guidelines and manual documents) were reviewed, updated, validated and disseminated.
- Strategy for private sector participation in malaria prevention and treatment was drafted and validated by the NMCP.
- Refresher training on malaria prevention and IPTp was conducted for 2,718 health personnel, and 1,988 CHWs were trained in IPTp.
- LLINs were distributed to vulnerable populations (pregnant women and children under 5) through ANC services by CHWs and a private sector partnership.

2. Capacity strengthening in malaria diagnosis and treatment:

- Normative documents were reviewed, validated and disseminated. These include guidelines, manual for RDT use at facility and community levels, Integrated Management of Childhood Illness (IMCI) and NMCP malaria case-management guidelines, MOH directives and training manuals for case management of malaria in pregnancy and NMCP national directives on malaria management and IMCI training modules.
- Training and refresher training was conducted for:
 - 24 OTSS supervisors in malaria diagnostics and new malaria guidelines
 - 224 health workers (126 clinicians and 98 laboratory technicians) in malaria diagnostics and case management
 - 51 laboratory technicians in malaria microscopy and RDT use
 - 72 health workers on clinical IMCI
 - 13 health workers and 15 facilitators on treatment of severe malaria
 - 1,376 health workers retrained in case management with ACTs, including

1,121 in the public sector and 156 in the private sector

- 99 health workers on case management of severe malaria using ETAT
 - 20 health workers on the collaborative approach
 - 1,214 CHWs retrained in iCCM and RDT use
 - 1,200 CHWs in community case diagnosis, treatment and referral for malaria, pneumonia and diarrhea, using MOH-approved guidelines and standards and RDT use and follow-up of pregnant women and their newborns
- Implemented mHealth pilot project for CHWs and health facilities using real-time data sharing (“case-sharing”) on malaria case management and drug stocks

3. Supporting health system capacity building to: provide and manage quality malaria treatment and control; collect, manage and use malaria health information for M&E and surveillance; and manage commodities and supply chains:

- Conducted training of officers for the operation of RMIS, HMIS and MEDISTOCK V4+, consisting of: (i) training in the use of system and (ii) provision of office equipment, computer equipment and consumables to health facilities in order to ensure sound statistical quality data.
- At the time of the visit, this system was effective but not used by all facilities.
- Provided technical and financial support to the NMCP to design and implement its Integrated Annual Work Plan.
- Set up technical working group meetings on supply chain management (4), BCC (2) and case management (1) and the development and validation of NMCP’s 2011-2015 M&E strategic plan.
- Supported an evaluation of existing health information systems.
- Secured office space within the NMCP for housing an integrated malaria data management system and provided RMIS technical support.
- Published RMIS bulletins.
- Conducted nationwide supervision of health zone data staff.
- Supported annual review of health zone data RMIS by organizing three regional workshops.
- Organized a workshop to train statisticians from six health departments, NMCP and SGS on LOGISNIGS.
- Carried out supportive supervision visits of health information staff in evaluation (3), supply chain management (6), BCC (2) and case management (1).
- Supported the review of CAME’s action plans and made recommendations.
- Conducted an ABC analysis and trained CAME staff on ABC analysis.
- Trained CAME Board of Directors on good governance and strategic monitoring.

ANNEX IX. CONSULTANT CONFLICT OF INTEREST STATEMENTS

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

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Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

<u>Barbara J. Jones</u>	<u>01/13/2015</u>
Signature	Date
<u>Barbara J. Jones</u>	<u>Consultant</u>
Name	Title

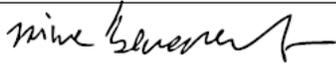
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PROJECT

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature 

Date **1/3/2015**

Jaime Benavente

Name

Title

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Read & Approved

Signature

M. Gub

Date

02/09/2015

Name

Title

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature  _____ Date 4/2/2015

Name TEPA Tenna _____ Title Research Assistant

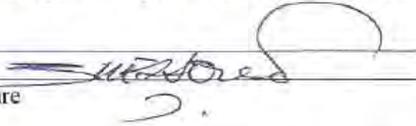
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature



Date

2015, Feb 23rd,

Name

KESSOU LEON KOKOU

Title

Consultant.

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