

FINAL EVALUATION OF THE COMMUNITY HEALTH INTEGRATED PROJECT FOR THE IMPROVEMENT OF MATERNAL AND CHILD HEALTH IN THE HEALTH DISTRICT OF MANGODARA, BURKINA FASO.



Acknowledgements

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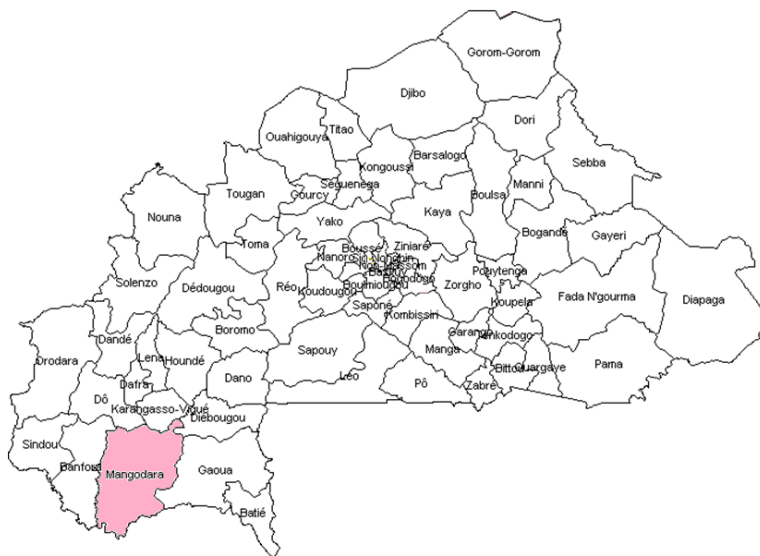
Introduction

This is an end evaluation of the Community Health RMNCAH project in Mangodara, Burkina Faso. (July. 2014 - June 2016), which is implemented by the Burkinabe Red Cross as auxiliary to the Government with technical and financial support from the IFRC and the Norwegian Red Cross. The overall objective of the project is to reduce maternal and child mortality by supporting and furthering MOH efforts.

The programme

The programme aims at reducing the numbers of women and children under 5 years old dying of preventable diseases in the cascade region, district Mangodara of Burkina Faso (BF). It targets 8 000 women of childbearing age, 1 800 pregnant women, 6 200 children under 5 years old, as well as related people (e.g. the men of women of child bearing age) in 50 villages.

Map of Country and the District.



The programme has 4 objectives:

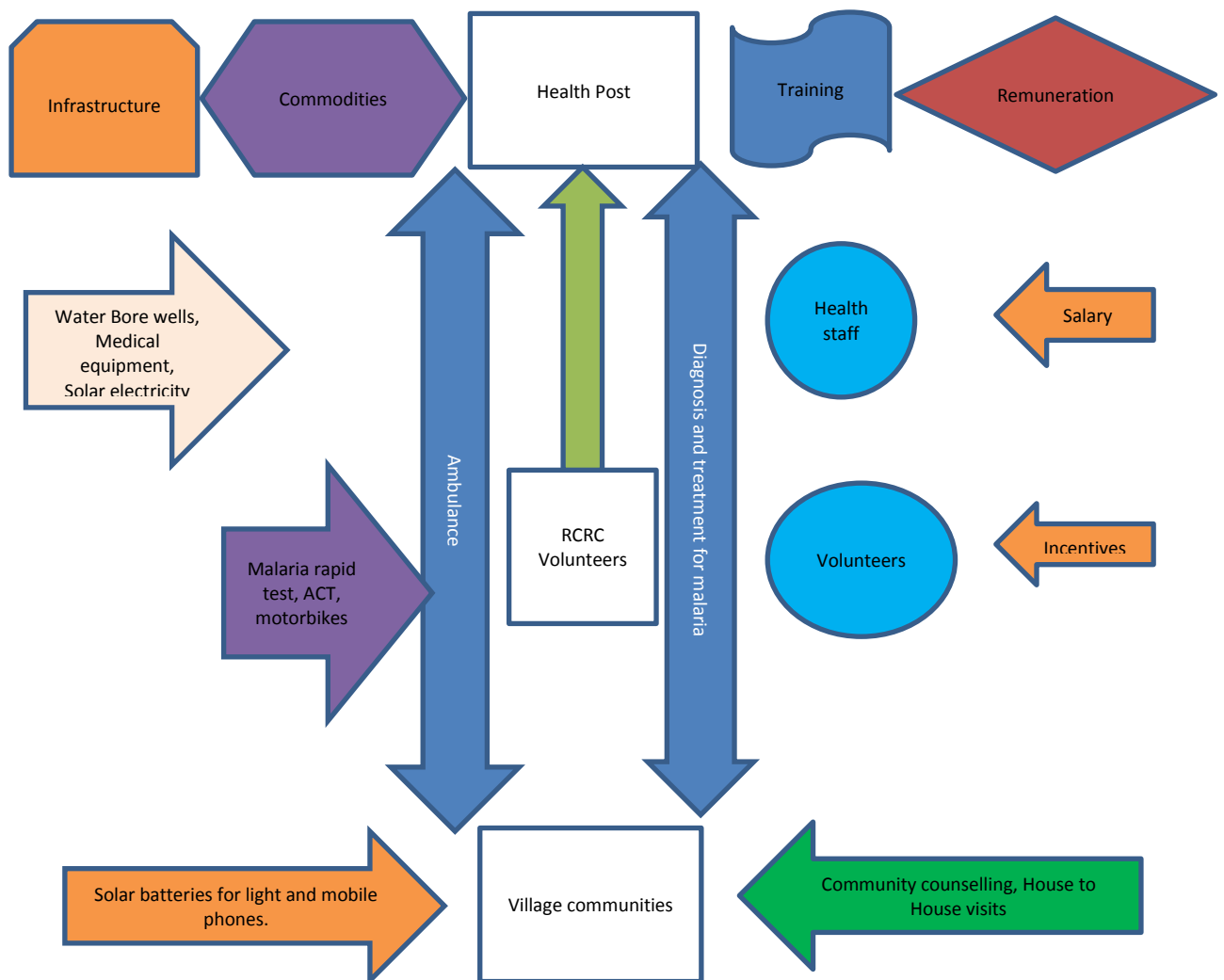
1. Improve access to quality health services and commodities for pregnant women, children under 5 years old in the selected villages (ANC, Delivery, PNC, new-born and infant care)
2. Improve knowledge and health care seeking behaviour among communities on Malaria prevention with diagnosis and treatment for under 5 yrs. old
3. The promotion of good hygiene, sanitation and use of drinking water
4. Capacity Building of the NS, its branches, of 08 CSPS and of the health district in general

The programme uses following strategies to reach these objectives:

1. Behaviour change communication on health seeking behaviour through trained health volunteers and facilitate access in the intervention villages;
2. Equip health facilities/ providers with knowledge and commodities at the health facilities and communities;
3. Engage with communities in WASH activities with provision of water source and diagnosis and treatment of malaria of under 5 years in villages;

The programme’s interventions aim at complementing the public health system, which is based on a decentralized three-tiered system of primary, secondary and tertiary care. The programme works mainly through MOH staff at health centres, Health Extension Workers at health posts and RCRC volunteers at community level. The work is implemented by the BF HQ and the implementing branch.

The bundles of activities (infrastructure, commodities, training and remuneration) and inputs (in arrows)



Methodology

This evaluation is following the principles laid out the IFRC Framework for Evaluation and using the RAMP technology for Survey. The objectives of the evaluation were mutually defined by the commissioners of the evaluation and the IFRC. This was presented by the Terms of Reference (available on demand). The evaluation was designed as being composed of two main parts: (1) a systematic evaluation of the overall project and (2) RAMP evaluation of key indicators used in the Baseline. The main part of this report is dedicated to the first part, while the second part can be found in annex.

Part 1: The objective is to assess the programme's effectiveness taking into account the principles spelled out by the IFRC evaluation framework (IFRC, 2011) and the IFRC mid-term evaluation framework (Netherlands Red Cross, Undated). Given that this is an end evaluation, we focus on the following aspects:

- Overall implementation of the programme
- Relevance
- Coverage
- Effectiveness
- Efficiency
- Community ownership
- Sustainability

Part 2: Using RAMP methodology - The questionnaire was tested and the field survey held from 11 to 16 May 2016. The survey was conducted in households, in a sample of 30 clusters from 26 villages (out of the 50 selected). The survey is a measurement of project completion indicators and beneficiary satisfaction.

The evaluation was based on a flexible protocol given the practical constraints (5 days of field visit work, including visits to the national office, travel to and from field sites in most remote villages of Mangodara).

Design of the systematic evaluation

Given the limited time on the ground, we focused on describing the actually implemented activities on the basis of observation, interviews and document review, and attempted to assess the outputs and their likely contribution to the expected results as presented in the logical framework. Because of

time constraints, it was decided to only visit the programme implementation sites in two villages – Dafinso and Farakoro. It was expected that the field evaluators would adapt it to the local circumstances, including the availability of respondents, transport issues, etc.

The protocol proposed to use a before-after design. In practice, we found that the data, available at branch level or presented in quarterly reports, precluded carrying out a full before and after comparison. Given the limited time on the ground for in-depth data collection, we focused on describing the actually implemented activities on the basis of non-participant observation, interviews and document reviews. We attempted to assess the outputs to see how these may contribute to the expected results as presented in the logical framework.

Data were collected from the following data sources:

- Project reporting and studies (project document, logical framework, baseline study, annual progress reports),
- Secondary data (strategy documents, IFRC strategy documents, MOH health sector strategies and RMNCH guidelines, donor expectations, etc.)
- In-depth interviews and informal discussions
- Field observations of project sites and activities.

Triangulation was carried out during analysis. Data were verified by interviewing different categories of people involved (beneficiaries, project staff, the Burkina Faso Red Cross Society HQ staff, health providers at different levels, different categories of volunteers, local MOH representatives) and through verification with secondary data sources.

Limitations of this study

Some limitations on the assessment were short time for the field visits. Even if we had two evaluators on-site, they could only obtain a limited view on the wide range of activities implemented within this programme, and in limited places. Second, not all data required for formulating full answers to the 'why' question could be collected which requires in-depth, repetitive and prolonged interactions which were difficult in short time frame. We acknowledge that some important information may have been lost in the translation process. As mentioned in the methodology section, the idea of using a before-after design was abandoned when during the field visit, the data constraints became apparent. Our review of annual and quarterly reports showed that performance is reported using a wide range of indicators, some of which get missed across reports. Furthermore, the target setting process was

not clear, and there are inconsistencies between targets presented by the logical framework and the targets used in the monitoring reports. Triangulation of BFRCS programme reports with MOH reports proved difficult. The members of the team who travelled to the field to collect the data noted that the data quality of the MOH Health Management Information System at district level was not clear at that level.

The data collection on the field met some additional constraints:

The branch office managers tended to designate volunteers for the interviews (introducing potential selection bias). Efforts were made to reduce this potential selection bias by choosing the candidate respondents ourselves whenever possible. Branch staff were present at most interviews (introducing potential respondent bias). The evaluation team consisted of persons representing the IFRC introducing potential respondent and reporting/analysis bias. Some important information may have been lost in the translation process. Here again, time constraints imposed some limits.

The programme implementation

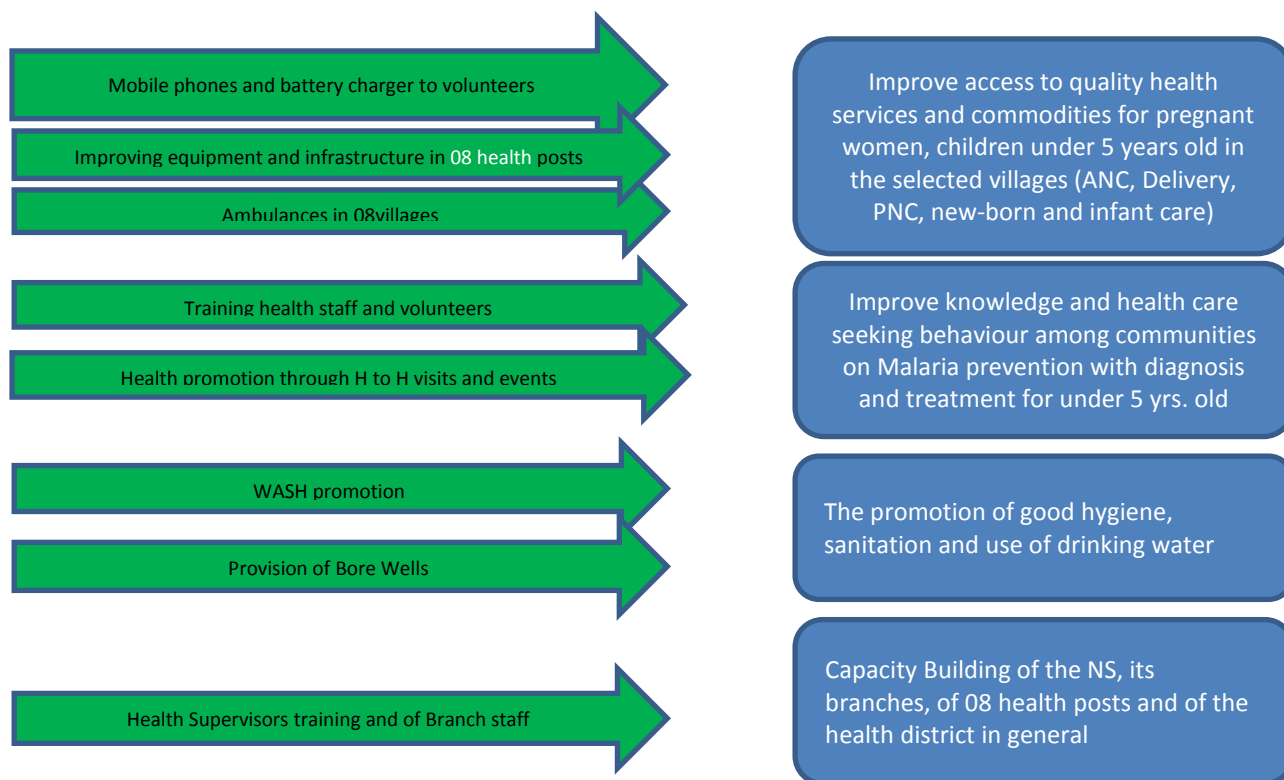
From July 2014, project activities mainly focused on the start-up. Although much of work and support was provided in the second quarter of 2014 from IFRC for preparation of budgets and action plans, stakeholder mapping. Baseline survey, recruitment and training of staff and volunteers happened from September 2014 onwards. After this phase, the programme activities were initiated. We show how during this period July 2014 to June 2016, most of the planned activities were implemented, and how they may be assumed to contribute to attaining the four objectives.

The programme had phases of slow down due to seasonal heavy rainfalls and the during the Ebola scare and preparedness phase. This resulted in some delays occurring in the purchase and distribution of commodities. However, these did not impact much to hinder field activities since the team at the field was wholly for this project and there were enough stocks in place through the project.

The following planned activities were implemented during the period September 2014 – June 2016 at the intervention sites:

- Volunteers and Health post staff were trained in ANC, PNC and maternal health care, using the MOH training modules and supplemented by training on reproductive maternal new-born and child health (RMNCH), as well as in CBHFA by the BFRCS. Health post staff were trained in IEC skills and hygiene management. MOH training modules were used, and additional training on RMNCH including PMTCT was given.

- Health volunteers conducted house-to-house visits and health promotion on ANC, PNC, hygiene and sanitation, malaria prevention and control and other health related topics
- Community conversations (CC) were organised by volunteers and volunteer supervisors with pregnant women, mothers and parents on topics related to neonatal health, ANC, and PNC.
- Couple counselling on birth preparedness was conducted at the health post.
- Nets distributed to mothers who gave birth at the health facility.
- Malaria diagnostic and treatment at community level by RC volunteers
- Eight (8) health posts have been provided with medicines and basic equipment (e.g. name the equipment beds, mats, blood pressure machines, stethoscopes, weighing scales, delivery table and material d'AMIU),
- Eight health posts and the district were provided with solar energy which was absent
- Diagnosis and treatment of Malaria for under 5 years old was done in the community.
- The referral system was strengthened through introducing referral forms and training on the procedures for the referral system for Volunteers and staff of health posts.
- Ambulances were provided in 08 villages for transportation of patients. The targeted approach used prioritised pregnant women and children under five-year-old.
- Mobile phone for each volunteer was given for improving reach and access to health posts.
- Financial incentives (salary, per diems) were provided to staff However volunteers were provided with others means of motivation such as torches, T-shirts- solar power kits and not financial incentives
- Project implementation review: meetings were organised with stakeholders, volunteers, the community the local authorities and health staff.
- The local branches were supported through supplying logistical support and staff training.
- As shown in Figure below, the project activities and strategies can be assumed to contribute in a complementary manner to attaining the 4 objectives.



Assessment

In this section, we present the findings of the assessment of the following criteria: relevance, coverage, effectiveness, efficiency, community ownership and sustainability. Below, we assess the programme along each dimension.

Relevance

Relevance is the extent to which the intervention is related to locally experienced vulnerabilities and follow local priorities (both on community and policy level).

Relevance is defined by the IFRC Framework as follows: *“Relevance focuses on the extent to which an intervention is suited to the priorities of the target group, (i.e. local population and implementers).”*

We focused on the alignment with local needs, local context and capabilities, national priorities and national policies and with BFRCS and IFRC policies.

Alignment with local needs

Before the start of the programme, an assessment was carried out to identify the local needs of the population. The data sources of this assessment were secondary data (census, DHS), communication

with the government and indicators from the MOH, a baseline study using a RAMP based household survey. Evidence-based interventions that could respond to local needs were identified through the literature and through guidelines. The programme designers took into account MOH recommendations. Other inputs were: international workshops, the community, and advice from the Norwegian Red Cross. We consider therefore that ample efforts were made to align the programme with the local needs, including induction workshops and inclusion of stakeholders in project design and planning.

During our field visits, the district-level MOH representatives at Banfora mentioned the following as priorities in their district: delivery at the health facility, malaria prevention, and water and sanitation. Beneficiaries, health staff, volunteers and the local government confirmed that the project activities were highly relevant and reaching the target population. People from the villages said they see the project as very useful and important. It is less clear to what extent there are mechanisms in the programme to elicit and take into account the expectations of the actors during the implementation phase.

Adaptation to local context and capabilities

Health staff reported that the designed interventions were contributing to the overall objective in a comprehensive way. Importantly, it seems that the local branch was given flexibility to adapt their activities to local needs (by design or by default) while staying consistent with the objectives of the project and the national priorities and guidelines.

Alignment with national priorities and with national policies

In general, the interventions of the project are in line with the national health policies. They contribute directly to SDG which is more integrated and holistic in its essence. These policies target important health problems: maternal and under-five mortality that remain at high levels despite recent progress. More specifically, the project objectives are aligned with the Health Sector Plan and the EWEC Roadmap related with maternal and new-born health. The programme's activities are well aligned with other interventions and policies that promote utilisation of health services by pregnant women (e.g. ambulance services, Free/ almost free services at health posts, etc.).

Alignment with BFRCS and IFRC

Strengthening the health system, mitigating and developing resilience within the community, and promoting health to vulnerable populations aligns well with the mission of the BFRCS and the global agenda of the IFRC.

Action points

- 1) The project is deemed to be highly relevant by the beneficiaries and local stakeholders interviewed. The project implementers benefit from some margin of flexibility to adapt the intervention to local needs. However, besides the initial needs assessment, there appear to be few mechanisms to involve the project's communities in the ongoing implementation in order to adapt the project to changing felt needs of the communities. Such a formal project mechanism would ensure continued alignment with local needs.
- 2) The Red Cross branches and volunteers are ideally placed to strengthen the linkages between the project and other sub-sectors of health wherein the Red Cross is active, such as health promotion, water and sanitation, vaccination programmes and CBHFA. More bridges could be built between the ongoing health promotion activities in the schools by Red Cross volunteers, involving the school staff, and the project's implementation activities, with a view of mutually reinforcing programme impact.
- 3) Our analysis of the logical framework prior to the field evaluation activities showed that the linkages between activities, objectives and assumptions are incomplete, and this is mainly due to the short time span for operations.

Coverage

Definition

The IFRC Evaluation Framework separates 'coverage' from 'effectiveness', and defines the former as *"the extent to which population groups were included / excluded"*. We assess coverage in terms of different dimensions. To assess coverage, a baseline study was done and other reliable sources that provide good value denominators were procured from Government sources based on which beneficiary numbers were set. However, the milestones and targets were not very well set, which were more often based on information available on village population and health indicators from MOH mentioned and the table below.

The total population of the Mangodara district is estimated to 205 740 inhabitants (source DGISS, 2014) for an annual growth rate of 4.87 %.

According to the Burkina Faso context these are the percentages for the target groups in a given population (Statistics of Mangodara district, from MoH source, 2014)

Expected pregnancies (1.20 Births X): 11 045

- Percentage of expected deliveries in a given population - Reproductive age women: 9204

- Percentage of women in child bearing age in a given population:
 - Children 6-11 months (0-11 months pop x 0.48): 4080
 - Children 0-23 months (7.74%): 16,130
- Proportion of children under 5 years old (18.456 %): 40,638
 - Children 6-59 months (16.393 %): 32,139
- The above were used when calculating the targets.

Table on Demographics of the project areas

- Total population in the 50 villages targeted by the project 34000
- Number of estimated HHs (1 HH = 7 persons): 4700
- Women of Reproductive age group: 8000
- Women Delivery group: 1800
- Lactating Women group: 1500
- Children under five year old: 6200

Issues: The **logical framework** presents expected results. It is unclear what are the milestones and targets set?

The source of the baseline data and the reasoning for setting the targets is not explained.

Similar limitations affect the BFRCS **baseline survey draft report**. This report presents the results of a cross-sectional study, carried out in villages of the intervention sites at the start of the study. It used RAMP questionnaire that included questions on socio-demographic characteristics, ANC, malaria, diarrhoea and sources of drinking water etc. In addition, focus group discussions, interviews and observations were carried out. The study estimated that the study population of women of reproductive age was 8000, and a sample of 329 women was drawn from this population. On this basis of the results of this survey, the monitoring system of the programme was primed. However, the baseline survey does not provide denominators.

The initial programme document, the logical framework, the indicator reports and the annual reports points to the issue of ambiguity in targets.

Assessment

Programme implementation intensity (proportionality)

The programme focuses on pregnant women and women who delivered, as well as on children under 5 years old. Given the high infant mortality and maternal mortality rates in BF, the programme is proportionate to need.

Who: Demographical analysis

With the currently available data and the available time, it proved impossible to accurately assess the coverage in terms of disaggregation of demographic data by geographic location and socioeconomic categories and marginalized populations.

Focus: Levels of coverage

Levels of coverage relate to the question whether and why support was provided according to need in different areas (national/regional). It is reported by the programme's narrative reports that infrastructure, logistics and management capacity in the branch were provided adequate support. There were no problems mentioned in interviews in the branch.

What needs (Cultural/political factors)

What constitutes "need," and therefore who is actually covered by the programme activities is a crucial issue, but here again, time and data were inadequate to do an accurate assessment on a micro level.

Action points

See the Effectiveness section below.

Effectiveness

Definition

Effectiveness is defined as the *"extent to which the objectives of the project, as set out in the project proposal and subsequent planning documents, were reached."* The programme has been very effective so far in strengthening capacity of village RC volunteers and health professionals attending to deliveries at health facilities, ensuring that the facilities are functional and task shifting for malaria diagnosis and treatment. This includes equipping health facilities with basic emergency obstetrical, child health care equipment and solar energy. The Burkina Faso Red Cross Society is complementing the government's efforts by supporting health personals and health volunteers which fall within existing government structure. Training and re-engaging traditional birth attendants in the promotion of safe motherhood has contributed positively to an increase in institutional delivery. Given that the programme has been very short and highly loaded with setting up capacity and infrastructure that sometimes there are some data gaps, we focus on the implementation process, outputs and acceptance of the programme.

Assessment

Implementation process

As discussed above under 'Implementation', the programme followed the sequence of activities as spelled out by the logical framework. The implementation of the interventions experienced some

delays due to seasonal monsoons, political crisis and Ebola scare. However, these were short lived. There were no delays owing to any budget issues, financial transfers and IFRC support.

Activities

At the moment of our visit, the interventions seemed very well implemented. The preliminary data looks promising, where the activity targets (as explained) are being reached (data for the complete set of indicators was not yet available). On data, the limitations discussed above apply, especially concerning the target setting and the use of absolute numbers. All training activities (of volunteers, Health workers, supervisors and communities) have been implemented as planned.

Health centres were equipped as planned, although the process of providing water supply started late bit has been completed. 4 Bore Wells have been constructed in villages as planned. The branch staff gave the impression to manage well the activities. Meetings were held on a regular basis and we noticed good communication and coordination with the stakeholders (government). However, some management issues emerged:

The branch office in Banfora once reported delays in procurement of Malaria treatment drugs and a slight delay in delivery of certain commodities from the headquarters. Other issues that were very subtly described was about the dependency of MoH authorities on RCRC support in these areas that may be not good for transition. It seems that there has been good coordination at higher level of the Ministry of Health, which sometimes lead to combined activities (e.g. for training activities and campaigns). This was mentioned both by the district MOH staff and the branch staff.

There were also delays in infrastructural works (branch office room). Transportation was never a problem as the project has been supported with vans, motorcycles at the operational levels.

Matrix for results and activities

Outcomes	Outputs	Activities	Initial target	Achieved
Outcome 1: Améliorer l'accès aux soins de santé de qualité pour les FAR, FE, les FA et les enfants de moins de 5 ans	Output.1.1: les femmes ont une meilleure connaissance de la santé maternelle	A 1.1.1: Organisation des visites à domicile auprès de 1800 FE, FA,	1800	1 710
		A.1.1.2: Préparation et mise à jour de la carte sociale communautaire	12 (1 fois par mois)	15
		A. 1.1.3 organisation des évènements sociaux afin de donner les informations sur la santé maternelle	3	2
		A. 1.1.4 Organisation de causeries d'informations avec les FE et mère d'enfants de moins de 5 ans	1800	1 710
		A. 1.1.5: Orientation des FE vers les Centres de santé pour les CPN les accouchements et les Consultation post natale	600	1 864
Outcome 2: Améliorer l'offre de soins pratiques pour les enfants de 0 à 24 mois)	Output 2.1: Les connaissances des mères d'enfants âgés de 6 à 24 mois dans les pratiques de soins de	A 2.1.1 Organisation de visites à domicile pour 2 300 enfants de 0 à 23 mois	2300	
		A.2.1.2: Organisation de causeries éducatives avec les FE sur le calendrier vaccinal	1800	1710
		A.2.1.3: Appui à l'organisation de la vaccination de routine en stratégie avancé pour 1 330 enfants et FE	1330	8 410

	santé essentiels sont améliorés)			
	Output 2.2: l'espacement des naissances est adéquate grâce à l'utilisation des méthodes contraceptives les FAR dans la zone d'intervention	A.2.2.1: Organisation de causeries sur le PF pour 7 700 FAR	1 800	4 011
		A.2.2.2: Orientation des FAR ayant besoin d'une contraception vers les centres de santé	900	216
Outcome 3: Renforcer les capacités des communautés en particulier les femmes à exprimer leur besoin de santé	Output 3.1: les capacités des communautés sont renforcées et sont à même de s'organiser de façon pérenne pour leurs besoins en matière de santé et plus	A.3.1.1: Mise en place des comités villageois de santé,	5	13
		A.3.1.2: Mise en place d'un fonds communautaire de santé maternelle et infantile	5	13
		A.3.1.3: Acquisition de 8 ambulances motos pour 8 villages pilotes	5	8

	specifiquement pour les FE et les enfants			
Outcome 4: Promouvoir les bonnes pratiques en matière de WASH auprès des communautés cibles	Output 4 1: Les ménages respectent les bonnes pratiques en matière d'eau potable, d'hygiène et d'assainissement(Wash)	A 4 1 1: Organisation de séances de sensibilisation sur le WASH (traitement de l'eau stockage et lavage des mains)	7500	18 854
		A 4 1 2: Organisation d'une session annuelle de promotion des activités WASH)	500	0
		A 4 1 3Construction de 4 forages pour favoriser l'accès à l'eau potable	4	4
		A 4 1 4: Mise en place d'un comité de gestion de chaque point d'eau	4	4
Outcome 5: Réduire la vulnérabilité des populations au paludisme dans villages cibles à travers des mesures de prévention)	Output 5.1: les connaissances des populations sont améliorés dans les villages cibles d'intervention	Organisation des causerie éducatives sur le paludisme auprès de 36 000 personnes	36000	43 189
		Organisation de visites à domicile par les volontaires auprès de 10 000 personnes	10000	15 849
	Output 5.2: les cas de paludisme simple chez	A 5 2 1: Acquisition de kits de diagnostic et de traitement du paludisme simple	1800	5 133

	les enfants de moins de 5 ans sont correctement diagnostiqués pris en charge au niveau communautaire dans 50 villages (avec les TDR et ACT)	A 5 2 2: Organisation du diagnostic et de la prise en charge du paludisme simple chez les enfants de 2 mois à 5 ans	1800	4 549
	Output 5.3: les cas de paludisme grave chez les enfants de moins de 5 ans, les cas de paludisme chez la femme enceinte sont pris en charge au niveau des formation sanitaire	A 5 3 1: Orientation des cas des suspect de paludisme chez la femme enceinte et les enfants de moins de 2 mois vers les centres de santé	240	284
	Output 5.4: les femmes enceintes et des enfants de moins de 5	A 5 4 1: Distribution de 1800 MILDA aux FE	1 800	1 661
		A 5 4 2: Organisation de VAD sur le paludisme (l'utilisation des MILDA) aupres de 4 500 personnes FEFA et FAR	4 500	5 765

	ans dorment sous MILDA			
Outcome 6: Renforcer les capacités de la SN et de ses branches (mise en œuvre, le partenariat, la documentation et recherche et l'évaluation)	Output 6 1: Les capacités humaines de la SN et de ses branches sont renforcées pour la mise en œuvre du projet	A 6.1.1: Organisation de 2 sessions de formation pour les 12 animateurs (WASH, NASG premiers secours	12	12
		A 6.1.2: Organisation de 3 sessions de formation pour les 156 volontaires (santé maternelle, WASH et NASG premiers secours	156	156
		A 6.1.3: Organisation de 2 sessions de formation pour 88 volontaires sur le diagnostic et le traitement du paludisme	88	100
		A 6.1.4: Organisation de sorties de supervision des activités des volontaires par les animateurs	12	12
		A 6.1.5: Organisation de sorties de supervision des animateurs par le chef de projet	6	12
		A 6.1.6: Organisation de sorties de supervision de l'équipe de projet par le coordonnateur santé	4	6
		A 6.1.7: Organisation de sorties de supervision de l'équipe de projet par le comité provincial	2	3
		A 6.1.8: organisation de sortie de supervision des activités du projet par le SG et la Gouvernance	2	1

	Output 6.2: Le plateau technique du district et des formations sanitaires est renforcé pour une meilleur prise en charge de la santé de la mère et de l'enfant	A.2.1: Organisation de deux sessions de formation pour 32 agents de santé du district sur la santé maternelle et infantile	32	36
		A. 6.2.2: acquisition de matériel medico-technique et consommable pour le district	2	2
		A. 6.2.3: assurer l'électrification solaire de 5 CSPS du district sanitaire de Mangodara	5	8
	Output 6.3: La Visibilité et le partenariat de la CR sont renforcés pour la mise en œuvre de projet intégré de santé communautaire plus étendu	A. 6.4.1 Organisation de sorties de couverture médiatique sur les activités du projet et acquisition de matériel de visibilité	2	3

Outputs

It is difficult to assess the clarity of targets and how these were defined. From interviews with the village members and branch, we learned that their knowledge and skills were improved through the programme and there has been more adequate support available in the intervention health posts since the project started. The health staff at HP gave the impression to be properly trained (e.g. community health volunteer received training in Integrated Community Case Management of malaria, able to answer technical questions of a decent level, they are knowledgeable about the basic preventive measures, etc.).

We learned that beneficiaries, volunteers, health facility staff and other stakeholders were highly optimistic about the programme. We did not record any obvious negative reactions. The beneficiaries also understood well that the Red Cross was responsible for these recent changes and activities in the community. This enhanced recognition, trust, and credibility of the Red Cross. Positive spill-over effects to communities outside of the project area was mentioned by project staff, volunteers and local ministry of health staff. We noted some problems. For instance, during the interviews with the Project staff and branches, immunization was barely mentioned. The branch staff, not all were trained on CBHFA and RMNCAH which requires further support.

Unintended results

Unintended effects, both positive and negative, include the following:

Positive: Some new interventions emerged in the community: e.g. the community ownership of the motor ambulances led to repairing of the roads to the health posts (at some places) by the community for easy access. The bore wells are maintained by the village that owns them with great pride. People do not enter the bore-well area with shoes on them. This has led to increased practices of hygiene.

Although we cannot draw strong conclusions concerning effectiveness owing to a very short implementation period, we noted some interesting findings concerning the programme design and implementation process:

Bundles of interventions: The project consists of various interventions that address the community in various ways: house visits with raising of awareness and assessing needs that can be supported by the project, community campaigns and conversations, bringing care to the community (malaria diagnosis and treatment) and health system strengthening with commodities.

Synergies: The interventions are synergetic. For example, the communities that are reached with messages are supported to access the clinics with ambulances. The volunteers in villages are connected with given mobile phones and solar batteries for quick communication and reach to health posts, the health posts have improved working standards and available services 24 hrs with commodities that make clinics functional (solar energy and equipment) all of this contributing to health behaviour change and decrease in morbidities and mortality.

There is a good coordination and collaboration with the local and national government (e.g. organization of trainings, planning of activities, etc.).

There is some flexibility at the level of the local branches (by default or by intention) in carrying out the predesigned interventions, which may contribute to adaptation to local context, if the required capacity is present. There is successful motivation of volunteer in the programme (e.g. through an innovative system to motivate them), and a follow-up/monitoring of their activities.

Integration: there is good collaboration within the programme between Health and WASH. Nutrition has been a recognised area and has been often discussed in the project.

TBAs support institutional deliveries and support health volunteers.

It can be argued that an approach that consists of bundles of interventions may be more effective than singular approaches. For example, the project promotes deliveries at the health facility, but also provides training to the health staff of these facilities and supports them in equipment and infrastructure. Moreover, as illustrated with the water bore wells and solar lamps in villages, interventions may reinforce each other's effect. All together, these interventions contribute to better quality of care. However, better involvement of local community representatives and beneficiaries would be needed to fully unlock the potential of such bundled programmes: it is important that supply and demand side interventions are synergetic.

Second, it seems important that there is room for national RC strategies or programmes to be flexible: if branch level staff can adapt the planned interventions to the local needs and capacities, the programme is likely to be more responsive. However, this requires some minimal capacity, resources along with supervision at branch level.

Action points

We suggest that urgent attention be given to the monitoring and reporting system:

The denominators: it is not clear what the denominators (for instance the number of expected deliveries or of pregnant women) with the result that project targets are not well defined.

The reporting practices may not be adequate to measure key outputs and outcomes.

The monitoring indicators for BFRCS programme needs a relook and simplified, in order not to overburden a relatively weak monitoring capacity at branch level. Examples (among others) of indicators which are difficult to monitor and added value to the monitoring of the program can be little:

- Pregnant women who timely reach health post
- Pregnant women who timely reach emergency obstetric care

Whether the monitoring and reporting system is harmonized with the systems of the Ministry of Health, is not clear. The monitoring system of the programme should be aligned and integrated in the governmental system in order to reduce workload and improve the quality of monitoring.

We recommend that the programme team revisits the target setting. For an example (similarly with other indicators): for each intervention zone, accurate data on the number of expected pregnancies should be obtained, either on the basis of extrapolation of DHS data or other national survey data or on the basis of routine data from the districts (if reliable). Then, in function of the local capacity, targets can be set for each zone, both in terms of absolute numbers, and relating to the denominators. Such targets should then be consistently used and applied across reporting formats.

Efficiency

Definition

Efficiency is defined as the extent to which the greatest possible impact has been achieved with the means available.

It is impossible to have a good assessment of the efficiency given that not all 'final' results are well known/can be assessed. We therefore focus on the issues of choice of contractors for equipment and infrastructure and procurement principles.

Assessment

The interviews with branch accountant suggest that the funds were being managed well according to the activities. Meetings were held on a regular basis and we noticed good communication and coordination within the project, National Headquarters and with other stakeholders. However, some management issues emerged:

A delay in fund transfer happens in the beginning of the fiscal year. This leads to slowing of activities or complete stop. As alleged in the interviews, this leads to channelling funds from various other Red Cross activities either in the same project or from other projects.

The branch office reported delays in delivery of certain commodities from the headquarters. Some requests were not given any response (e.g. a request of the RC branch governance to be provided with funds to carry supervision).

The maximum amount to make purchase in the branch level was CHF 130 which was deemed not sufficient and above which three quotations are required and is a lengthy process.

The programme decisions were with just the chief coordinator in NHQ for all matters. This seems to create some vacuum of decision-making during the person's absence and often could have interfered in the communication between national and branch level.

Other issues that were raised by respondents include inadequate coordination at higher level, which sometimes leads to overlapping activities and delays (e.g. for training activities).

There were also delays in infrastructural works (branch office rooms, health centre infrastructure, etc.) because of a lack of skilled people (e.g. engineers) in the area. At places logistics were limited - e.g. there were transportation problems for movement of commodities.

The total budget for 2 and half years has been CHF 397 127. The three large expenses in the project are – Capacity building/trainings, purchase of medicines, & equipment and salary of staff (in decreasing order). With symbolic motivation to volunteers the least.

Salary of staff is low at approx. 8% of the overall expenses with one project officer and one accountant on the staff roles in each branch. Overall, the absorption capacity for funds is good.

At branch, the staff reported that the budget was spent 40% in 2014, 55% in 2015 and 5% in 2016.

The capacity at branch level to handle expenses and budgets is good. There is full time accountant and the Head of finance at the HQ to oversee and make sure the project expenses are compliant to donor requirements Both are working and are trained in financial management.

The programme (in all project areas) has reached out up to 97% of the targeted people in two and half year, for some specific component like WASH, others villages outside the target areas are using the water points provided by the project. All staff were recruited. Comparing the programme indicators with the coverage, there is either a very good coverage with activities and supplies and sometimes surpassing the targets that have been set for the overall project period. This raises questions on selection of targets and matching of funds with activities under each outcome.

Several factors may contribute to the relatively low cost:

Cost is relatively low due to very low personnel costs, as the programme uses the 'Health volunteers', whom it pays just some incentives/per diems.

The programme strategies / activities are inter-linked and complementary to the public health system and thus do not require very heavy investments in infrastructure, training, etc.

Action points

Increase in threshold from minimal level for project purchase without quotation at a policy level.

Including indirect costs in the budget for labour and distribution of commodities.

Activities in difficult to reach terrains need to consider an extra cost or else they are not realistic.

Better planning and coordination with the government at higher level, facilitate communication for joint planning at district levels could avoid too much overlap of activities.

Community ownership

Definition

Community ownership is generally defined as the *“extent to which the communities in the project area were/are involved in project design, prioritisation, feedback mechanisms and decision making during implementation.”* The IFRC Framework refers to community ownership indirectly, i.e. in relation to appropriateness, including *“how well the intervention takes into account the economic, social, political and environmental context, thus contributing to ownership, accountability, and cost-effectiveness. When applicable, it is particularly important that the evaluation function supports a community’s own problem-solving and effective decision-making to address local needs, and build community capacity to do so in the future.”*

We focused on the involvement of local actors and beneficiaries and the perceptions of ownership among other stakeholders.

Assessment

Involvement of local actors and beneficiaries

While the needs assessments on which this programme is based involved consultation of the population, their active involvement once the programme started was limited. There appear to be no formalized mechanisms, in the visited project implementation sites, to involve different social groups or community structures in project-related decision-making processes (apart from local government authorities and local MOH representatives). Nor are there formal project-initiated community feedback mechanisms.

We further noticed limited involvement of spontaneous community initiatives or any other community structures.

This does not mean that local people are not involved. Although no differentiation was made in the project design as regards the specific needs of vulnerable groups, different people from different social strata and ages are involved in the project activities. We found that the project approaches people on the basis of their respective social roles: adolescents, community leaders, volunteers, pregnant women, non-pregnant women of child-bearing age, men, fathers, couples, households, etc. However, it seems these actors are rather informed and perhaps consulted, but not given an active role in monitoring and decision-making.

Perceptions of ownership among other stakeholders

During our field visits, we attended one project review meeting and observed that there was both strong ownership of the project among the volunteers, community and staff.

Also local government actors and MOH representatives are engaged with, and coordination between the programme and these actors is good.

Since the start of the programme, the Ministry of Health has been closely involved: the MOH was involved in the program design and the selections of the villages. Examples of this are - campaigns and workshop organized with regional and local MOH representatives, the headquarters staff from the headquarters, and the branch staff.

However, at district level, there was no evidence of any multi-sectoral project committee being set up, to assist in embedding the programme into the local structures.

The project is integrated with and complementary to the public health system but more work is required on empowerment and strengthening of mechanisms at the MoH level to help provide continuity.

We noted above that there is a good alignment of the programme with priorities at national, district and *village* level. However, this alignment is not resulting from a very active involvement of beneficiaries in decision-making, which maybe again that the project hasn't had the time to mature and just been set up. In settings where established hierarchical structures do not spur involvement of specific community groups or individuals (e.g. women, marginalized groups, etc.) or where historically political structures were heavily centralised, such groups will not normally demand involvement in project decision-making processes, nor seek to provide feedback: they are part of / have internalized the existing power structure. In these settings, spaces will need to be created to effectively adapt the project's strategies to local needs through avenues of creating community dialogues and discussions.

Action points

We would suggest the following points for consideration:

1. To explore the creation of formal and structured community feedback mechanisms and decision-making processes (e.g. initiating/reinforcing regular community talks on project implementation, setting up a project steering committee with local stakeholders, including community representatives, etc.) or to create synergies with existing community feedback mechanisms or structures.
2. To consider stimulating further synergies with local communities' initiatives and grassroots organisations, faith based associations, women groups etc.

Such activities would aim at embedding the programme's activities deeper into the local social fabric.

Sustainability

Definition

Sustainability is *"the extent to which the results and the activities of the project are likely to be continued or be of use after the end of the implementation period, up to three years (minimum)."*

Assessment

At this moment, we cannot fully assess the sustainability criterion. In this section, we only point to some issues that may have an influence in terms of implementation modalities and context conditions and categorise them as either potential facilitators or barriers to sustainability.

Facilitators include investment in equipment, tests, medicines and infrastructure, capacity building of providers and volunteers, effect on motivation, and the availability of community members, and the integration of activities in local MOH plans and activities.

Our evaluation found that the project is highly valued by the health staff and the volunteers, in itself an essential condition for programme sustainability.

According to the beneficiaries, health staff, and local MOH, the staff and community learned about the importance of the interventions and they are willing to carry the programme forward. They also kept presenting the desire to reinforce the programme basics by supporting minimum essential activities during the lean phase by support from any partner if possible. This is relevant because the programme is yet in a very nascent stage when it finished.

The project improved eight health facilities and it is likely that equipment and infrastructure will be used after project closing.

Capacity building of health providers: if remaining in place, providers will be able to use the improved skills.

The involvement of community authorities (including opinion leaders, etc.) contributed to developing local solutions (e.g. for maintaining roads, wells, ambulance bike etc.) and may facilitate sustainability, assuming this is a sign of ownership.

It is also likely that there will be sufficient candidates to join the programme, especially as volunteers, which is considered to be an honour.

The project activities were developed and integrated into the programmes of MOH at district and village level, increasing the chance of institutionalisation if the project could continue for at least 2 more years.

Barriers may include:

The potential loss of the branch-level managers: critical is the role of the BFRCs staff at the branch, now consisting of 1 project coordinator at NHQ and 1 project accountant in NHQ who coordinate with the branch manager. Supervisors of volunteers are salaried workers covered by the project. Their term will end when the project ends which may probably affect sustainability.

Incentives: Within the new Govt policy the CHWs will be recruited on a salary. The payment of incentives to volunteers will not match well with the national policy and this might start the loss of social capital. The reactions of respondents indicate that this intervention may not be maintained in its present form if salaries are given to village workers. Some respondents (local and higher level within the RCRC) expressed the feeling that the volunteers should be intrinsically motivated and not through incentives.

It should be noted that the programme document doesn't discuss the exit strategy, and that there seems to have been a very little discussion of the exit at branch level. Attention to exit needs to be given in every project.

Alignment with local needs, integration in existing local systems during the implementation and alignment of national priorities seems to be favourable for current implementation and future sustainability, but the exact contribution of the above-mentioned facilitators and barriers needs attention if the project goes ahead with any other funding.

Action points

We found little discussion of the programme's exit strategy, and this needs more attention.

Also, the issue of volunteer incentives and CHW salaries, and its relation to national and local policies needs to be looked into.