USAID/Burundi Integrated Health Project/Burundi Mid-Term Performance Evaluation

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Cover Photo: Burundi woman with children. Photo credit: USAID/Burundi
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We appreciate the extraordinary contribution of IHPB staff in freely providing the team with in-depth information on the project’s progress in responding to the bilateral contract’s scope of work. We also note, with deep appreciation, the time and the effort IHPB staff expended in assisting the team as we addressed the many technical, logistical, and administrative issues associated with defining the evaluation’s site selections and its key informant pool and in liaising with respondents at all levels. Without this important assistance, we could not have carried out our assigned tasks.

Finally, we acknowledge, with thanks and appreciation, the positive collaborative environment established, from the outset of the evaluation, by the USAID/Burundi team responsible for giving us guidance and direction as we defined the evaluation methodology, collected and analyzed data, and prepared multiple drafts of the report.
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# ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>AMTSL</td>
<td>Active Management of the Third Stage of Labor</td>
</tr>
<tr>
<td>ANC</td>
<td>Ante Natal Care</td>
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<td>ANSS</td>
<td>Association Nationale de Soutien aux Séropositifs et aux Malades du Sida</td>
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<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
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<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
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<tr>
<td>BDS</td>
<td>Bureau de District Sanitaire (District Health Bureau)</td>
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<tr>
<td>BEmOC</td>
<td>Basic Emergency Obstetric Care</td>
</tr>
<tr>
<td>BRAVI</td>
<td>Burundians Responding Against Violence and Inequality</td>
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<tr>
<td>CCM</td>
<td>Community Case Management of Malaria</td>
</tr>
<tr>
<td>CD4</td>
<td>Cluster of Differentiation 4</td>
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<tr>
<td>CDS</td>
<td>Centre de Santé (Health Center)</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<tr>
<td>CLA</td>
<td>Collaborating, Learning, and Adapting</td>
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<td>CLIN</td>
<td>Contract Line Item Number</td>
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<tr>
<td>CME</td>
<td>Continuing Medical Education</td>
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<td>Contract Officer’s Representative</td>
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<td>COSA</td>
<td>Comité de Santé</td>
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<td>Civil Society Organizations</td>
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<td>Commercial sex workers</td>
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<tr>
<td>CTR</td>
<td>Counseling, testing, and referral</td>
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<tr>
<td>DMPA</td>
<td>Depot medroxyprogesterone acetate</td>
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<tr>
<td>EID</td>
<td>Early Infant Diagnosis</td>
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<td>EOP</td>
<td>End-of-project</td>
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<tr>
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<td>Focus Group Discussion</td>
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<td>Gender Based-Violence</td>
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<td>GH Pro</td>
<td>Global Health Program Cycle Improvement Project</td>
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<td>Government of Burundi</td>
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<td>HIV</td>
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<tr>
<td>SOW</td>
<td>Scope of Work</td>
</tr>
<tr>
<td>SWAA</td>
<td>Society for Women against AIDS in Africa</td>
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<tr>
<td>SWOT</td>
<td>Strengths and Weaknesses, Opportunities and Threats</td>
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<td>TOT</td>
<td>Training of trainers</td>
</tr>
<tr>
<td>TPS</td>
<td>Technicien de Promotion de la Santé (Health Promotion Technicians)</td>
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<td>UNICEF</td>
<td>The United Nations Children's Fund</td>
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<td>United States Agency for International Development</td>
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<td>United States Government</td>
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EXECUTIVE SUMMARY

EVALUATION FRAMEWORK

Objective and Purpose: The evaluation’s principal objective was to assess progress that the Integrated Health Project Burundi (IHPB) has made through September 2016 in achieving its objectives and document the effectiveness of the project’s approaches and responsiveness to integrating and improving health behaviors, services, and systems. Thus, the evaluation addressed four questions related to its stated purpose:

1. To what extent has the IHPB achieved its intended objective to increase quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?
2. To what extent has the IHPB achieved its intended objectives to strengthen health capacity and systems?
3. How well is the integration of health services approach working in the covered area?
4. What lessons learned can inform project management for the remainder of the project life and future potential follow-on designs?

Audience: The primary audience for this evaluation is the USAID/Burundi Health Office. Other users include the USAID Washington Global Health Bureau, USAID Presidential Malaria Initiative, and the Office of the Global AIDS Coordinator, who have all contributed funds to implement the project. Other key audiences include the Burundi Country Representative; the USAID/Burundi Program Office; the Embassy Bujumbura Front Office, in the context of their collaboration to implement the IHPB; and USAID/Rwanda. The findings will be used by USAID/Burundi and the implementing partner to develop and support activities to strengthen the project’s objectives of improving performance over the remaining project life, helping USAID determine what steps to take to sustain the project achievements, and helping USAID design future health activities.

Background: The Republic of Burundi, a landlocked central African nation with approximately 11 million inhabitants, borders on the Democratic Republic of the Congo, Tanzania, and Rwanda. Based on health-related data obtained from the 2010 Burundi Demographic and Health Survey and from the 2016 Population Reference Bureau (provided in parentheses in this report, if available), the total fertility rate of women of child-bearing age equals 6.4 children per women of reproductive age; 21% of women received prenatal consultations during the early stages of pregnancy and 33% of women complete at least the recommended number of four prenatal visits; 11% of women use modern contraceptive methods; 1.4 % of males and females between the ages of 15-49 are sero-positive for HIV/AIDS (1% for males and 1.7% for females); during their first year of life, 63 children out of 1,000 infants do not survive; and 79% of children under 12 months of age receive recommended immunizations. Finally, based on data obtained from the World Health Organization (2015), there were approximately 4.5 million confirmed cases of malaria in 2013. In 2014, 64 of 1,000 suspected cases submitted for either microscopic analysis or for rapid diagnostic tests (RDTs) were confirmed positive for malaria. Burundi has one of the highest maternal mortality ratios (712 per 100,000) in the world.
The Integrated Health Project Burundi works with the Government of Burundi (GOB), civil society organizations (CSOs), communities, and other development partners to integrate and improve health behaviors, services, and systems across families, communities, facilities, and districts. The project builds on USAID's legacy of support to address HIV/AIDS, malaria, family planning and reproductive health, and maternal and child health needs in Burundi. At the end of the project's five years, the Burundian government, CSOs, and supported communities will have demonstrably increased capacity to deliver quality integrated health and support services and communications and behavioral interventions. In addition, the implementing partner shall have contributed to the increased sustainability of project investments in a measurable manner. In working toward this purpose, the project works with the following four provinces and with 12 districts (see Figure 1) within the four provinces: (Karusi Province: Buhiga and Nyabikere Districts; Kayanza Province: Kayanza, Musema, and Gahombo Districts; Kirundo Province: Kirundo, Busoni, Mukenke, and Vumbi Districts; and Muyinga Province: Muyinga, Giteranyi, and Gashoho Districts).

Methods
This evaluation used a combination of qualitative and quantitative methods of primary data collection. Primary data were supplemented by secondary data from the IHPB project and from U.S. and Burundi government documents. Using standardized quality-focused, open-ended Key Informant Interview (KII) and focus group discussion (FGD) questionnaires in each of the IHPB's four client provinces and 12 districts, the evaluation team visited 23 IHPB-supported facilities; 30 KIIs were conducted with 65 participants; and 27 FGDs were conducted with 61 service providers, 33 community health workers, and 33 client beneficiaries. All informants were selected based on their involvement with and/or knowledge of the IHPB.

In addition, in its qualitative approach to assessing the IHPB's mid-term performance, the evaluation focused on gaining the perspective of health service providers and clients on each of the scope of work’s four questions. Following the completion of all KIIs and FGDs, the evaluation team developed a summary of cross-cutting themes associated with informants’ responses rather than attempt to provide a statistically unsound enumeration of the number of informants who replied in a specific way to each of the evaluation’s open-ended questions.

Limitations and Constraints

- Due to budgetary constraints, the limited number of analysts available necessarily dictated the use of convenience sampling in selecting a sample of the 176 facilities enrolled in the IHPB program as of September 2016.
- Similarly, logistical and time constraints necessarily restricted the evaluation team’s ability to assess more than the 23 facilities in the convenience sample.
- In applying convenience sampling to the selection of the 23 facilities included in the site surveys, USAID guidelines called for the survey to be conducted in all 12 IHPB districts. As such, given the time allocated to the survey by the scope of work, it was not logistically possible to select more than two facilities per district. Indeed, in some districts, only one facility was selected. As the evaluation team and USAID made every effort to select sites that were both urban and rural, there is no reason to expect that those facilities not selected for the survey would have produced results different from those that were selected.
• As specified in the scope of work and as agreed upon with USAID, the evaluation team’s principal focus was on a qualitative approach based on information gained through 23 site visits during which observations and perceptions of service providers were gained through open-ended standardized discussions structured around 22 KIIs (with a total of 34 participating respondents) and 25 FGDs (with a total of 110 participating respondents). As such, the evaluation did not have the mandate nor the technical focus to explore in-depth information obtained through the evaluation’s quantitative examination of available project performance data.

• Finally, as this evaluation is mainly concerned with implementation issues, the evaluation team’s reliance on descriptive methods necessarily limits the evaluation’s statistical rigor.

PRINCIPAL FINDINGS

Question 1: To what extent has the IHPB achieved its intended objective to increase quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

At hospital level, the evaluation’s respondents reported that the project’s intended objective was achieved principally through its promotion of: (i) the decentralization of the provision of antiretroviral therapy (ART) to health center level; (ii) support for biological monitoring (viral load, polymerase chain reaction (PCR) and cluster of differentiation 4 (CD4) count of People Living With HIV (PLHIV); (iii) training in the provision of neonatal care and deliveries; (iv) provision of laboratory equipment; (v) provision of vasectomies and tubectomies; and (vi) training of health providers in HIV testing, treatment of malaria, maintenance of medical equipment, and management of medical waste.

At health center level, respondents reported that the IHPB achieved its intended objectives through the promotion of: (i) the provision of joint HIV testing for couples; (ii) the identification of HIV+ individuals through mobile testing at identified hot spot areas and among family members of PLHIV; (iii) the introduction of a new protocol for the reduction of malaria morbidity and mortality through early diagnostic and treatment of cases and; (iv) capacity building of health personnel in the provision of care focused on improving client health care through reinforcement of provider skills in a number of critical areas, including, inter alia, Basic Emergency Obstetric Care (BEmOC), Prevention of Mother to Child Transmission of HIV (PMTCT), and malnutrition care.

At both hospital and health center level for the 23 facilities surveyed, 15 (64%) offered varying levels of availability of the full array of possible modern family planning methods, including pills (64%), injectables (64%), male (64%) and female (50%) condoms, and implants (41%). In addition, 14% of surveyed facilities (the majority of which were hospitals) were equipped to provide vasectomies and tubectomies. In addition, among the 23 surveyed facilities, eight (36%) were religiously-affiliated. Among these facilities, none offered any modern contraceptive methods. In all such facilities, clients were reportedly counseled on natural family planning through the use of cycle beads (colliers du cycle) for the control of pregnancy during periods of high fecundity.

At community level, respondents reported that the IHPB achieved its intended objective through training and support of community health workers (CHWs) to work with neighboring health centers and communities in the promotion of (i) HIV prevention, family planning,
immunization awareness; (ii) HIV testing through the “hot spot” mobile strategy, (iii) community case management of malaria (CCM); and (iv) joint HIV testing for couples. In addition, the evaluation team’s discussions with health center staff and our review of IHPB’s training records indicate that the project has provided significant training assistance to health centers to respond to the need for improved quality of emergency obstetric care.

Responding to gender-based violence (GBV) at all levels

Given the widespread incidence of gender-based violence within Burundi, the project has organized training sessions for service providers focused on improving their capacity to assist GBV victims in their efforts to overcome the resultant trauma. As a result, service providers are, in theory, better prepared to provide effective post-exposure counseling and treatment for women who are victims of assault. However, although kits for post-exposure GBV prophylaxis are generally available at health centers, service providers reported that, due to the affected population’s reluctance to acknowledge incidences of GBV, few cases of GBV were actually treated by health services surveyed during the evaluation.

In the evaluation team’s discussions with health providers on the importance of the provision of GBV services to the well-being of their clients, service providers confirmed the existence of an elevated incidence of GBV within communities. In this regard, health service providers cited community-level examples of GBV that included, *inter alia*, physical attacks and wounds during pregnancies, violent non-consensual sex, and spousal demands for additional children. However, despite their training, health service providers, by their own admission, are ill-equipped to respond to physical and psychological trauma experienced by victims of gender-based violence.

Question 2. To what extent has the IHPB achieved its intended objectives to strengthen health capacity and systems?

As a cross-cutting theme among KIs and FGDs at the 23 surveyed facilities, respondents frequently recognized that IHPB has improved health system management capacity as a whole by supporting the training and supervision of human resources, providing medical equipment, supporting infrastructure rehabilitation, assisting in procurement and supply chain management, and through training health service managers in integrating service delivery data for decision-making purposes focused on improving the delivery of services.

With reference to the IHPB’s two-year progress in developing the organizational and technical capacity of three Burundian CSOs—Association Nationale de Soutien aux Séropositifs et aux malades du SIDA (ANSS), Society for Women Against AIDS in Africa Burundi (SWAA-Burundi) and Réseau Burundais des Personnes vivant avec le VIH/SIDA (RBP+)—IHPB’s March 2016 evaluation report on the three organizations’ level of organizational and technical capacity concluded that each of them would have sufficient capacity to transition and manage USAID-funded future technical contracts.

Question 3: How well is the integration of health services approach working in the covered area?

From the perspective of senior health center staff, integration of services has resulted in the reduction of time spent by clients on repeat visits to a health center and in an increase in early ante natal care (ANC) consultations reportedly due to the clients’ knowledge that free HIV testing would also be available. A somewhat unexpected but credible impact of integration was the informants’ belief that the acceptance of community-based provision of condoms and pills
for family planning—and the strengthening of the role of the CHW—was due to clients’ initial introduction to the importance of family planning following deliveries and during well-baby visits at health centers.

However, despite the evidence that there was a significant degree of understanding associated with the potential impact of integration, the evaluation team did not observe any health facilities in which the full-scale program of integration of all potential services was a standard practice. Indeed, in most cases, the application of integration was province-specific: in Karusi Province, emphasis was placed on integrating family planning and HIV; in Kayanza Province, emphasis was placed on integration of family planning in maternal health and HIV services; in Kirundo Province, emphasis was placed on integration of antenatal care, GBV, screening for malnutrition and HIV testing; and in Muyinga Province, emphasis was placed on integration of PMTCT and malaria management. Reasons cited for the project’s challenges associated with integrating services in health centers included: (i) shortages in the number of personnel available to provide services; (ii) the limited number of personnel trained in integration; (iii) personnel attrition; (iv) the sheer volume of clients requesting services; and (v) “...smart integration opportunities that can primarily contribute to the achieved of the contractually-defined mandatory results.”

Finally, while much of the evaluation’s emphasis was placed on gaining the field perspective of service providers and clients with reference to the quality of IHPB’s performance, the evaluation team also undertook a quantitative analysis of the extent to which the IHPB’s reporting on Year 3 (Y3) on its Performance and Evaluation Plan provided insight on its progress toward meeting requirements associated with its principal performance indicators.

Quantitative Analysis of IHPB’s Performance

In documenting the project’s response to mandatory indicators incorporated in its 2015 Y3 monitoring and evaluation plan (PMEP), IHPB’s records provide performance data on 73 (97%) of the PMEP’s 73 Y3 indicator targets. Of the 73 PMEP indicators with recorded Y3 results, the project reported that it had achieved 100–150% of its targets for 25 (34%) of 73 PMEP indicators. In addition, the project reported that it had achieved greater than 150% of its targets for 18 (25%) of the 73 PMEP indicators. Moreover, for those 43 indicators for which the project had achieved at least 100 percent of Y3 targets, the level of achievement against these indicators ranged from 100–411%, with a mean of 146% achievement of targets and a median of 120% achievement of targets.

CONCLUSIONS (QUESTIONS 1-3)

In its discussions with administrators, health providers, CHWs, and clients, the evaluation team has identified a significant amount of strengths associated with the evaluation’s central focus: To assess progress that the Integrated Health Project Burundi (IHPB) has made to date in achieving its objectives and document the effectiveness of the project’s approaches and responsiveness to integrating and improving health behaviors, services and systems. At the same time, the evaluation team has identified a number of challenges that remain to be addressed if the IHPB is to maintain its progress toward responding to the project’s central focus: To increase capacity to deliver quality integrated health and support services and communications and behavioral interventions.

Major Strengths

- Although heavy daily patient flow and the limited number of service providers at the majority of health centers prevented the full integration of all services, all respondents
recognized that improved client access to integrated services—such as pre-natal care and HIV/AIDS testing or MCH and malaria prevention—represented an important contribution to the improved quality of services.

- Equipment provided by the project enabled the health centers and hospitals to improve the quality of care, especially during deliveries.
- The improvement of community-based health services contributed to the development of a bridge between the communities and their health centers.

**Major Challenges**

- Personnel trained and supervised by the project were too few in number to provide realistic expectations that the government will be able to sustain the project’s progress in promoting effective integration of services.
- Limitations in the number of health center staff and in the health centers’ basic infrastructure, coupled with staff turnover, continue to impact negatively on the IHPB’s progress on introducing integration as a means of promoting quality health care.
- Although respondents at both hospital and health levels acknowledged the quality of IHPB training, staff turnover and the limited number of staff trained were cited as challenges to the ability of health services to ensure and maintain quality standards of care across all health providers.
- The project’s limited success in facilitating effective joint planning with hospitals and districts is a challenge that, if addressed during the project’s remaining two years, can make a significant contribution to expectations of sustainability following the project’s completion in September 2018.

**LESSONS LEARNED**

*Question 4: What lessons learned can inform project management for the remainder of the project life and future potential follow-on designs?*

At district health officer levels, there was general agreement that a major lesson learned was that project initiatives cannot be sustained unless there is full and effective involvement of district managers in the planning and implementation of a technical assistance project. With reference to this lesson learned, district health officers—as well as health facility managers—recommended that the IHPB, during its remaining two years, increase its efforts to more fully integrate district health officers in the planning and execution of the project’s activities.

At the hospital level, key informants reported that without attention being directed toward enabling hospitals to fulfill their role as technical resources for their client health centers, there is limited expectation that the project’s technical interventions can be sustained.

From the perspective of health center professionals, CHWs, and clients, a key lesson learned was that integration has played a key role in changing the mentality of the population on the expanded role of the health center as a principal force for preventive health care. Similarly, health center service providers have learned that meaningful involvement of trained CHWs represents a critical component to a community’s improved standard of health care. At the same time, health center service providers have learned that without effective and supportive
supervision, any gains in their technical service delivery capacity stand a limited chance of being sustained.

PRINCIPAL RECOMMENDATIONS
2016–2018: In the next 18 months:

- The project should immediately engage an outside educational consultant to work with project technical staff and with district technical staff as a team in the definition and implementation of an intensive training of trainers (TOT) program for selected health service providers with a focus on enhancing and sustaining project progress on the integration of basic health services.

- Given the fact that, for 25% of its Y3 PMEP performance indicators, the IHPB exceeded established targets by more than 150%, USAID and IHPB should work together on an analysis and re-adjustment (if indicated) of targets for Y4 and Y5. In doing so, all parties will have achieved a more realistic estimation of the IHPB’s potential for further advancing the project’s potential outputs for its remaining two years.

- As a participatory process with the full engagement of central, provincial, and district-level government officials, the project should immediately work on defining and implementing an action-oriented strategy to implement its exit plan.

- In support of a Collaborating, Learning, and Adapting (CLA) process and in the interest of enhancing prospects for sustainability of its progress on integration, the project should devote sufficient time, during the project’s final quarter of operations, to the preparation and the dissemination (through workshops or symposiums) of detailed documentation on the project’s progress on its initiatives as well on lessons learned during the project’s five-year operation.

Goals for a Future Project

It is recommended that any future project with a technical focus similar to IHPB’s should:

- Plan from the outset to ensure long-term sustainability.

- Work toward maximum flexibility in the project’s execution through the contract’s definition as a cooperative agreement.

- Balance the provincial and central project structures and functions:

  At the province level, it is recommended that the project:

  - Focus on the development and support of provincial hospitals as centers of excellence.

  - Provide for fully-staffed provincial-level senior-level technical teams responsible for developing the capacity of the provincial hospitals’ centers of excellence and for facilitating the formation, support, and capacity development of a permanent hospital-based integrated services team (IST).

  - Support the role of provincial hospitals’ centers of excellence and their ISTs as focal points responsible for assessing and responding, through a defined action plan, to
integrate health capacity-development needs of districts, hospitals, and health centers within the province.

- Support the development, implementation, and monitoring of an IST-developed provincial project exit plan that emphasizes promoting the long-term sustainability of initiatives introduced by the IST.

At the central level, it is recommended that the project:

- Continue its current efforts to monitor and ensure that the project fulfills its contractual obligations.

- Provide for a small central-level core group (perhaps one senior technical officer and one management officer per province) to ensure that each provincial team has full-time access to senior-level technical support/oversight and to all necessary material, logistical, and administrative support.

- Work with the Ministry of Health to promote the adoption and institutionalization of policies associated with the promoting the IST’s provincial-level initiatives.

- Develop an initiative with the Ministry of Secondary and Higher Education focused on promoting the introduction and government support for an integration curriculum into Burundi’s medical and training schools.

- Proactively coordinate the monitoring of all provincial exit plans.
I. BACKGROUND

The Republic of Burundi, a landlocked Central African nation with approximately 11 million inhabitants\(^1\) borders on the Democratic Republic of the Congo, Tanzania, and Rwanda. Based on health-related data obtained from the 2010 Burundi Demographic and Health Survey\(^2\) and from the 2016 Population Reference Bureau\(^3\) (provided in parentheses in this report, if available), the total fertility rate of women in child-bearing age equals 6.4 children per woman of child-bearing age; 21% of women received prenatal consultations during the early stages of pregnancy and 33% of women complete at least the recommended number of four prenatal visits; 11% (30%) of women use modern contraceptive methods; 1.4 % of males and females between the ages of 15-49 are sero-positive for HIV/AIDS (1% for males and 1.7% for females); during the first year of life, 63 children out of 1,000 infants born do not survive; and 79% of children under 12 months of age receive recommended immunizations. Finally, based on data obtained from the World Health Organization,\(^4\) there were approximately 4.5 million confirmed cases of malaria in 2013. In 2014, 64 of 1,000 suspected cases submitted for either microscopic analysis or for rapid diagnostic tests (RDTs) were confirmed positive for malaria.

THE INTEGRATED HEALTH PROJECT BURUNDI (IHPB)

As described in the evaluation’s scope of work, the USAID/Burundi Integrated Health Project Burundi:

Works with the Government of Burundi (GOB), civil society organizations (CSOs), communities, and other development partners to integrate and improve health behaviors, services, and systems across families, communities, facilities, and districts. The project builds on USAID’s legacy of support to address HIV/AIDS, malaria, family planning (FP) and reproductive health (RH), and maternal and child health (MCH) needs in Burundi. At the end of the project’s five years, the Burundian government, CSOs, and supported communities will have demonstrably increased capacity to deliver quality integrated health and support services and communications and behavioral interventions. In addition, the implementing partner shall have contributed to the increased sustainability of project investments in a measurable manner. In working toward this purpose, the project works with the following four provinces and with 12 districts (see Figure 1) within the four provinces: (Karusi Province: Buhiga and Nyabikere Districts; Kayanza Province: Kayanza, Musema, and Gahombo Districts; Kirundo Province: Kirundo, Busoni, Mukenke, and Vumbi Districts; and Muyinga Province: Muyinga, Giteranyi, and Gashoho Districts).

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\(^1\) Population Reference Bureau, 2016
\(^3\) Population Reference Bureau, 2016
\(^4\) World Health Organization, *World Malaria Report 2015*
Project Summary

The Integrated Health Project in Burundi has three integrated objectives:

1. **Increased positive behaviors at the individual and household levels**

   Contract Line Item Number (CLIN) 1 includes IHPB’s activities in social and behavior change communication (BCC) (sub-CLIN 1.1), supply chain management (sub-CLIN 1.2), and gender integration and gender-based violence (GBV) service strengthening (sub-CLIN 1.3).

   - Sub-CLIN 1.1: Improved key behavioral pre-determinants at the individual, household, and community levels
   - Sub-CLIN 1.2: Increased accessibility and availability of health products to individuals and households
   - Sub-CLIN 1.3: Strengthened support for positive gender norms and behaviors and increased access to GBV services

2. **Increased use of quality integrated health and support services**

   CLIN 2 serves as the locus of IHPB’s work to support strengthening and expansion of community health workers and community health committees (Comité de Santé or COSA) (Sub-CLIN 2.1); continuation of essential services and prioritization, testing, and roll-out of
integrations and improvements to services (Sub-CLIN 2.2); and strengthening the capacity of the District Health Bureaus (Bureau de District Sanitaire or BDS) human resource management system and health facility managers (Sub-CLIN 2.3).

Sub-CLIN 2.1: Increased access to health and support services within communities

Sub-CLIN 2.2: Increased percent of facilities that provide quality integrated health and support services

Sub-CLIN 2.3: Increased capacity of providers and managers to provide quality integrated health services

3. **Strengthened health systems and capacity**

CLIN 3 activities will strengthen the capacity of local district partners to plan, oversee, manage, and deliver essential and integrated services in an effective, efficient, and responsive decentralized health system. Under Sub-CLIN 3.1, IHPB will help the GOB put in place the policies, district management capacities, infrastructure, and equipment needed to support essential and integrated health services. Under Sub-CLIN 3.2, the project will help districts put data quality systems in place, reform data flows, and continuously improve how data is analyzed and used in routine monthly and quarterly meetings. Under Sub-CLIN 3.3, the project will provide intensive technical assistance and grants to four CSOs to strengthen their critical roles in district health systems, including service delivery, governance, and community mobilization.

Sub-CLIN 3.1: Strengthened decentralized health care and systems in targeted geographic areas

Sub-CLIN 3.2: Strengthened monitoring and evaluation (M&E) and data management systems at facility and community levels

Sub-CLIN 3.3: Increased civil society capacity to support positive behaviors and quality integrated services

Accordingly, the management of the IHPB’s organigram (Annex F) is designed to provide technical assistance to each of the project’s three objectives.
II. PURPOSE AND METHODS

EVALUATION PURPOSE AND QUESTIONS
The evaluation’s principal objective was to assess progress that the Integrated Health Project Burundi has made to date in achieving its objectives and document the effectiveness of the project’s approaches and responsiveness to integrating and improving health behaviors, services, and systems. Thus, the evaluation contained four questions related its stated purpose:

1. To what extent has the IHPB achieved its intended objective to increase quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?
2. To what extent has the IHPB achieved its intended objectives to strengthen health capacity and systems?
3. How well is the integration of health services approach working in the covered area?
4. What lessons learned can inform project management for the remainder of the project life and future potential follow-on designs?

METHODS
On September 10, 2016, USAID/Burundi approved the methodology for the IHPB performance evaluation (Annex B). The principal components were:

Data Collection
A combination of qualitative and quantitative methods of primary data collection was applied in this mid-term evaluation. Primary data were supplemented by secondary data from the IHPB project and from relevant United States Government (USG) and Burundi government documents (Annex E.)

Qualitative Data Collection
In IHPB’s four client provinces and 12 districts (Karusi Province: Buhiga and Nyabikere Districts; Kayanza Province: Kayanza, Musema, and Gahombo Districts; Kirundo Province: Kirundo, Busoni, Mukenke, and Vumbi Districts; and Muyinga Province: Muyinga, Giteranyi, and Gashoho Districts), 22 key informant interviews (KIs) with 34 participating respondents were conducted with senior technical officers over a 14-day period during on-site visits to 23 IHPB-supported facilities (three provincial hospitals, four district hospitals, 14 health centers, and two IHPB-supported CSO’s service delivery facilities). In addition, KIs were conducted with technical representatives of two health district offices, of IHPB’s provincial offices, and of IHPB’s central office, with technical representatives of the three IHPB-supported civil society organizations—Society for Women against AIDS in Africa (SWAA), Association Nationale de Soutien aux Séropositifs et aux Malades du Sida (ANSS), and Réseau Burundais des Personnes vivant avec le VIH (RBP+)—and with USAID/Burundi’s Contract Officer’s Representative (COR) in Bujumbura. In total, 30 KIs were conducted with 65 participants. In addition, during on-site visits to the 23 health facilities, 27 focus group discussions (FGDs) were conducted with 61 service providers, 33 community health workers, and 33 client beneficiaries. All informants were selected based on their involvement with and/or knowledge of the IHPB.
As the first step in the evaluation’s selection of sites, USAID/Burundi and the evaluation team recognized that, given the fact that only 12 days were available for field visits, it would not be possible to visit all sites as part of the IHPB’s qualitative performance evaluation. Accordingly, in consulting the IHPB’s annual and quarterly reports, USAID and the evaluation team agreed on the following preliminary selection criteria for selecting among the IHPB’s 176 potential sites:

- Sites with reported high performance (i.e., provincial hospitals)
- Sites with reported average performance (i.e., district hospitals)
- Sites with reported low performance (i.e., health centers and IHPB-supported CSOs service delivery centers)

In addition, with reference to health centers, the criteria for selection also called for considering sites from among those health centers that had reportedly worked with the IHPB in introducing quality improvement approach measures as well as those that did not.

Based on the above initial selection criteria and on the IHPB’s health facility data base, the evaluation team worked with USAID to apply the process of convenience sampling5 in arriving at a final selection of sites discussed above.

Two separate field teams comprised of three experts for Muyinga and Karusi; two experts for Kayanza and Kirundo administered the questionnaires and the field team leaders checked the completeness and quality of the data. To facilitate entry and analysis, notations on all hand-filled questionnaires were converted to electronic copies formatted in MS Word following each day of site visits.

KIIs and FGDs used open-ended questions (Annex C) to help the team understand to what extent the IHPB’s approaches, support, and responsiveness to integrating and improving health behaviors, services, and systems had led to improved quality in the delivery of services. Evaluator notes on informant responses were electronically recorded using MS Word. To respect informant anonymity, responses were then entered into an electronic master file for all responses with the identity of respondents effectively masked. The resultant master file is available upon request.

**Quantitative Data Collection**

In addition to qualitative data collected during the site visits, quantitative data was collected during on-site observations at 14 facilities using a standardized data collection instrument (Annex C). Recording of on-site observations focused on validating information on project inputs that were reported upon in the project’s annual and quarterly reports. Although limitations in time available for the site visits dictated that all instruments were tested during the first day of data collection, results of this testing indicated that no additional changes were needed. Finally, with reference to the evaluation’s quantitative data collection, the evaluation team reviewed data available on the IHPB’s reported achievement of indicators for the third year (Y3) of IHPB operations (October 2015 – September 2016).

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5 In applying convenience sampling, “the most common of all sampling techniques,” the evaluation team makes no claim that the statistics apply to all IHPB client facilities. As agreed to by USAID/Burundi, the team used convenience sampling to help in “documenting that a particular quality of a substance or phenomena [e.g., enhanced quality in the delivery of services through integration] occurs within a given sample” (https://explorable.com/convenience-sampling).
Review of Secondary Sources
The team reviewed IHPB, USAID, and national documents to supplement primary data collected. Among documents reviewed were the IHPB contract and project management reports; technical, financial, and administrative reports; and the USAID-approved IHPB Project Monitoring and Evaluation Plan (PMEP). Also reviewed were GOB reports and narratives, especially the *Enquête Démographique et de Santé 2010* (Demographic and Health Survey for 2010) as well as a five-year series of national statistical reports (e.g., *Paquet Minimum d’Activités (PMA)* 2015) that provided informative data on Burundi’s district-specific service delivery statistics. Data from these sources were used to provide quantitative context to qualitative information collected during the evaluation team’s field visit KII, FGDs and site observations.

Data Analysis
**KII and FGD qualitative data** were summarized for each interview and compiled in a master file that was organized thematically based on the questions posed in the scope of work to inform the evaluation. An analysis of the thematic summaries was also used to expand upon and validate findings from the quantitative analysis.

**Analysis of quantitative data**, although not the focus of this qualitative evaluation, quantitative data were entered into two separate Excel spreadsheets, one for the analysis of the on-site observations and a second for an analysis of the project’s progress against the attainment of Y3 indicator targets. As data was entered and cleaned, cross-tabulations were generated for issue-focused analyses and illustrative tables and figures with the results subsequently triangulated in an effort to validate findings associated with the more in-depth qualitative analysis.

Ethical Considerations
Because this evaluation is concerned with program management, no approval was required from any ethical review body. However, IHPB obtained formal approval from the national Ministry of Public Health and from the four provincial medical directors prior to the evaluation team’s visits to provincial and district health facilities. No patient information or identifiers were retained after the evaluation. Also, before beginning any KII or FGD interviews, oral consent was obtained from all respondents using a standardized form (Annex D). Finally, in respecting the consent form’s assurance of confidentiality, all identifiers of respondents are excised from information in this report, and its annexes.

Limitations and Constraints
- Due to budgetary constraints, the limited number of analysts available necessarily dictated the use of convenience sampling in selecting a sample of the 176 facilities enrolled in the IHPB program as of September 2016.
- Similarly, logistical and time constraints necessarily restricted the evaluation team’s ability to assess more than the 23 facilities in the convenience sample.
- In applying convenience sampling to the selection of the 23 facilities included in the site surveys, USAID guidelines called for the survey to be conducted in all 12 IHPB districts. As such, given the time allocated to the survey by the scope of work, it was not logistically possible to select more than two facilities per district. Indeed, in some
districts, only one facility was selected. As the evaluation team and USAID made every effort to select sites that were both urban and rural, there is no reason to expect that those facilities not selected for the survey would have produced results different from those that were selected.

- As specified in the scope of work and as agreed upon with USAID, the evaluation team’s principal focus was on a qualitative approach based on information gained through 23 site visits during which observations and perceptions of service providers were gained through open-ended standardized discussions structured around 22 KII (with a total of 34 participating respondents) and 25 FGDs (with a total of 110 participating respondents). As such, the evaluation did not have the mandate nor the technical focus to explore in depth information obtained through the evaluation’s quantitative examination of available project performance data.

- Finally, as this evaluation is mainly concerned with implementation issues, the evaluation team’s reliance on descriptive methods necessarily limits the evaluation’s statistical rigor.
III. FINDINGS

[In responding to the evaluation scope of work’s four questions, the following report on findings refers to the first three of the four questions. As the fourth question centers on the evaluation’s recommendations, please see Section VI for a response to this final question.]

**Question 1**: To what extent has the IHPB achieved its intended objective to increase quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

**Introduction**: In addressing Question 1, the evaluation team focused on determining if interventions implemented by the IHPB were effective, innovative, and if they contributed to increased quality and use of integrated health and support services for HIV/AIDS, malaria, FP, and MCH. The evaluation’s findings are based on a qualitative analysis of responses to the following five sub-questions, each of which was addressed during the team’s standardized key informant interviews with 57 respondents in the 12 districts included in the four IHPB provinces: Karusi, Kayanza, Kirundo, and Muyinga. Findings arrived at during the evaluation team’s site visits were enhanced and triangulated with findings associated with the team’s quantitative analysis of project-related documentation and records.

1.1 What aspects of the IHPB Project have been most effective? In what ways have they been effective? Why have they been effective?

1.2 What, if anything, is innovative about the IHPB’s approach to increasing the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

1.3 What are the “best practices” instituted by the IHPB in addressing ways in which to increase the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

1.4 With reference to the IHPB, what are the least successful approaches applied by the program towards addressing ways in which to increase the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

1.5 Has IHPB incorporated principles of gender equality and empowerment in the design and implementation of activities, such as through ensuring an inclusive approach to addressing any gender specific barriers to increasing the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

1.1. What aspects of the IHPB Project have been most effective? In what ways have they been effective? Why have they been effective?

At hospital and health service level, respondents reported that IHPB, through the quality of its technical training and the systematic availability of material support, has been effective in improving the quality of care provided in a significant number of health services. At hospital level, respondents reported that IHPB technical training was most effective in promoting: (i) the decentralization of the provision of antiretroviral therapy (ART) to health center level; (ii)
support for biological monitoring (viral load, polymerase chain reaction—PCR and CD4 count) of People Living With HIV (PLHIV); (iii) training of health workers responsible for the provision of neonatal care and deliveries; (iv) provision of laboratory equipment; and (v) training of health providers in HIV testing, treatment of malaria, maintenance of medical equipment, and management of medical waste.

At health center level, respondents reported that IHPB training and material support was most effective in interventions through the promotion of: (i) the provision of joint HIV testing for couples; (ii) the identification of HIV+ individuals through mobile testing at identified hot spot areas and among family members of PLHIV; (iii) the introduction of new protocols for the reduction of malaria morbidity and mortality through early diagnostic and treatment of cases; and (iv) capacity building of health personnel in the provision of care focused on improving client health care through reinforcement of provider skills in a number of critical areas including, inter alia, Basic Emergency Obstetric Care (BEmOC), Prevention of Mother to Child Transmission of HIV (PMTCT), training in promoting and providing client access to the full array of modern contraceptive methods (except in areas where a facility’s religious affiliation precluded such training) and malnutrition care. The project has also provided protocol and guidelines, including laminated copies of an implementation guide for Intermittent Preventive Treatment for malaria in Pregnancy (IPTp), algorithms on IPTp, ART guides, PMTCT guides, case management of malaria, post exposure prophylaxis (PEP) guides, and HIV testing and counseling (HTC) standard operating procedures (SOPs).

In addition, in evaluating the IHPB’s contribution to increased quality and use of integrated health and support services for HIV/AIDS, malaria, FP, and MCH, IHPB training and support of Community Health Workers (CHWs) was universally reported—by health service managers, service providers, and by clients themselves—as having been effective in promoting the development of a service provision bridge between communities and their health centers. A list of such interventions would include, inter alia, training in the promotion of modern family planning methods; training in community case management of malaria (CCM); malnutrition screening and initial treatment and the identification and referral of children with severe malnutrition; training in Supply Chain Management (SCM), including dispensation, storage, distribution, monitoring, and reporting of health commodities at the community level; the provision of basic supplies and equipment, including notebooks, stock cards, gloves, saddlebags, safety boxes, and solar lamps; and financial and technical support for monthly CHW meetings.

From the perspective of community health workers, the most effective interventions of the project are related to the training they have received on various topics, including HIV prevention; family planning and immunization awareness; training in the provision of health care at the community level, such as HIV testing through a “hot spot” mobile strategy; counseling offered for joint HIV testing for couples testing; orientation of the community in the use of mosquito nets especially for children and pregnant women; integrated CCM; and the promotion of health center support for malaria and childhood immunization at the community level.

With reference to project inputs focused on improving quality of care, new equipment donated to health facilities assisted health centers in improving the quality of services, including those associated with neonatology, biological monitoring associated with laboratory diagnosis, and intra uterine device (IUD) and implant insertions and removal. During the 13 FGDs with health
center staff, the IHPB’s promotion of village-level provision of contraceptives (condoms, pills, and injectables) was commonly cited by participants as being an important contribution to the reduction of the flow of clients at the health facility and to the concomitant increase in the ability of staff to devote increased attention to clients’ curative care requirements.

1.2 What, if anything, is innovative about the IHPB’s approach to increasing the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

In approaching this question, the evaluation’s respondents were asked to identify the extent to which the IHPB technical training had introduced new interventions that demonstrably altered service providers’ ability to provide improved quality of service. While the IHPB assistance focused on improving the quality of services across all four project technical areas, those areas in which IHPB interventions were considered by respondents to be truly innovative included (i) introducing an Emergency Triage Assessment and Treatment strategy to decrease the child mortality rate in hospitals; (ii) piloting of integrated community case management (iCCM) to decrease child mortality/increase early childhood disease management, (iii) integration of PMTCT and early infant diagnosis (EID) of HIV into routine newborn and child health care, (iv) rolling out and implementing IPTp during prenatal visits, (v) case management of gender-based violence, and (vi) integrating the introduction to family planning for clients seeking curative care.

Finally, although not widely implemented throughout the project’s 173 client facilities, the project’s limited scale training in quality improvement (QI) was cited as being an innovation. For the first time in respondents’ experience, those who were trained in QI were introduced to the concept of a team working together to collectively identify and address service-wide constraints or bottlenecks to the effective promotion of integrated health services.

1.3 What are the “best practices” instituted by the IHPB in addressing ways in which to increase the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

In assisting the evaluation’s participants in identifying IHPB best practices, the evaluation team asked 80 health service providers to identify IHPB interventions that had consistently led to improved outcomes. While a large number of best practices were subsequently identified, the following citations of best practices were those that were first identified during initial KII and FGDs and were then validated across the majority of subsequent interviews.

• Although integration was considered by respondents to be an innovation when applied to the interventions noted above, the project’s promotion of integration was also considered to be a best practice. For example, in the case of family planning, the project’s promotion of an integrated approach to responding to a client’s family planning needs while also addressing her child’s immunization needs was a best practice that clearly resulted in the reduction of both missed opportunities and of the need for a client to visit the health center for another visit.

• In addition, as a best practice commonly cited by health service managers, the project’s work with health facilities to increase their capacity to more reliably identify root causes associated with maternal mortality reportedly led to a more focused approach to the reduction of mortality occurring in deliveries.
• Similarly, the project’s training of health providers in the application of Active Management of the Third Stage of Labor (AMTSL) was cited as a best practice as it reportedly also contributed to a reduction in maternal mortality.

• Although most of the 30 clients who participated in the evaluation agreed that stigma and discrimination in HIV counseling, testing, and referral (CTR), the project’s training of health center staff in the organization and provision of mobile testing in community-level testing for HIV in identified “hot spots” was cited by service providers as reportedly contributing to more focused identification, counseling and care of PLHIV in the community. The project’s promotion of HIV “hot spots” was cited by health providers as an important step toward increasing the early detection, counselling, and treatment of PLHIV.

• In addition, rolling out and implementing IPTp in the IHPB-assisted health centers reportedly led to 71% (Year 2) and 79% (Year 3) of women attending antenatal clinics receiving IPTp under direct supervision of a health worker. As a best practice, timely administration of IPTp has been shown to result in a reduction of malaria cases and pregnancy complications.6

• Finally, at the community level, the evaluation team’s discussions with service providers and with CHWs indicates that the project’s work on providing training to CHW and its focus on promoting community-level behavior change was considered by many respondents as constituting a best practice in that it reportedly led to an increase in demand for health services and to an acceptance of the role of integrated services as a means of increasing the quality of health care.

1.4 With reference to the IHPB, what are the least successful approaches applied by the program towards addressing ways in which to increase the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

At the hospital level, despite the availability of new equipment thanks to IHPB, equipment maintenance remains an issue due to the project’s limited emphasis on training in equipment maintenance and to health facilities limitations in funding to support maintenance.

In addition, support provided by IHPB was consistently cited by district-level managers as being “paternalistic.” From the perspective of these managers, IHPB participation in “joint planning exercises” with the districts was focused on the IHPB’s targets and on USAID reporting requirements rather than on what hospital and health districts considered to be their real needs. While it is understandable that the project was concerned with meeting its contractual obligations, district-level managers and health service personnel felt that health system constraints, such as those associated with sub-par conditions of basic health service infrastructure and with the limitations in availability of health service personnel, were not taken into consideration during planning exercises.

Moreover, although the project’s objective focused on promoting integration as a means of improving the quality of health care services, a review of the project’s organigram (Annex F) indicates that IHPB’s management and provision of technical assistance were built around a vertical model that focused on “silos” of technical assistance dedicated to malaria, HIV/AIDs, MCH, Family Planning and Maternal, Neonatal and Child Health (MNCH) rather than on

6 Malaria Policy Advisory Committee Meeting September 11-13, 2012, WHO HQ
promoting the concept of integration. While discussions with IHPB indicated that IHPB technical
officers’ field visits to client health facilities focused on an integrated approach to the provision
of technical assistance, the evaluation team’s review of health facility records indicated that IHPB
visits to health facilities during 2016 were dedicated to the provision of technical assistance for
specific health interventions rather than to the promotion of integrated services. At the end of
2015 and in response to the vertical nature of the project’s central-level management of
technical assistance, the IHPB established branch offices of Program and Technical Officers for
each province with polyvalent staff whose responsibilities included providing more direct
technical support to their client health facilities. Based on this improved model for project
technical assistance, the evaluation has suggested a recommendation (please see Section VI of
this report) that a province-centric model be adopted as the basis for a revised approach to
providing technical assistance under a potential future project.

At the health facility level, respondents identified a number of constraints associated with
their limited ability to take full advantage of the project’s assistance:

- Time required to effectively introduce integration was a frequently-cited issue of some
  concern.

- Insufficient knowledge about the maintenance of equipment provided by the project
  appears to have contributed to a lack of confidence among staff that use of such
  equipment could be sustained. In addition, in several instances, on-site observations
  indicated that some maternity equipment remained unused and in their original delivery
  packaging, reportedly because the facilities in question had no access to electricity
  required to operate project-obtained equipment.

- Without an effective program dedicated to training of trainers (TOT), turnover and
  attrition of health providers would appear to be an issue with impact on the permanent
  need for training of new personnel and retraining or refreshment of skills required to
  sustain the project’s introduction of interventions and maintain the health services
  quality of health care promoted by the project’s effort.

- Although imposed as a result of the President’s Emergency Plan for AIDS Relief
  (PEPFAR) budgetary constraints, the sudden termination of support for HIV in Muyinga
  and Karusi provinces has severely limited these provinces’ ability to continue HIV-
  related quality of care improvement with specific reference to biological monitoring
  (viral load and Polymerase Chain Reaction or PCR), HIV testing at community level, and
  supportive supervision by physicians to health centers providing HIV services.

- During its first three years of operation, the project focused its attention on responding
  to training targets without a countervailing emphasis on post-training supportive
  supervision. As a result, many of the gains in capacity achieved through training have
  reportedly diminished. In addition, when supportive supervision is undertaken by the
  project, follow-up on the project’s supervision recommendation is limited due to what
  would appear to be weak collaboration between the project and some districts.

Although IHPB quarterly and annual reports indicate that health service staff were
trained in data collection and in data management—and, in limited cases, provided with
computers—the project’s limited focus on developing health center managers capacity
to effectively use data for decision-making purposes was cited by respondents as a significant IHPB technical weakness. In exploring this issue during KIIs, health service staff indicated that the effort spent in collecting data for transmission to districts could have been more effective and productive had project staff and district managers devoted more time and effort to working with health center staff to provide feedback on the data. From the perspective of health center informants, focused feedback on data would have assisted health centers in building on identified strengths and in responding to identified challenges.

1.5 Has IHPB incorporated principles of gender equality and empowerment in the design and implementation of activities, such as through ensuring an inclusive approach to addressing any gender specific barriers to increasing the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

**Responding to Gender-Based Violence**

Given the widespread incidence of gender-based violence within Burundi, the project has organized training sessions for service providers focused on improving their capacity to assist GBV victims in their efforts to overcome the resultant trauma. As a result, service providers are, in theory, better prepared to provide effective post-exposure counseling and treatment for women who are victims of assault. However, although kits for post-exposure GBV prophylaxis are generally available at health centers, service providers reported that, due to the affected population’s reluctance to acknowledge incidences of GBV, few cases of GBV were actually treated by health services surveyed during the evaluation.

In the evaluation team’s discussions with health providers on the importance of providing GBV services to the well-being of their clients, service providers confirmed the existence of an elevated incidence of GBV within communities. In this regard, health service providers cited community-level examples of GBV that included, *inter alia*, physical attacks and wounds during pregnancies, violent non-consensual sex, and spousal demands for additional children. However, despite their training, health service providers, by their own admission, are ill-equipped to respond to physical and psychological trauma experienced by victims of gender-based violence.

**Question 2. To what extent has the IHPB achieved its intended objectives to strengthen health capacity and systems?**

**Introduction:** In addressing Question 2, the evaluation team focused on determining the extent to which interventions implemented by the IHPB contributed to capacity building of health care systems and to systems associated with the delivery of HIV/AIDS, malaria, FP, and MCH services. The evaluation’s findings are based on a qualitative analysis of responses to the following three sub-questions, each of which was addressed during the team’s standardized KIIs with 57 respondents in the 12 districts included in the four IHPB provinces: Karusi, Kayanza, Kirundo, and Muyinga. In addition, the KII responses were supplemented by group discussions with health care providers, CHWs, and clients. Finally, findings arrived at during the evaluation team’s site visits were enhanced and triangulated with findings associated with the team’s quantitative analysis of project-related documentation and records.

2.1 In what way has the IHPB contributed to capacity building of health systems?
2.2 In what way has the IHPB contributed to capacity building of HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services?

2.3 With reference to the IHPB, have there been any barriers to the ability of the IHPB to capacity building of health services and systems? If so, how would you describe these barriers and their impact, actual or potential, on the project’s execution?

2.1 In what way has the IHPB contributed to capacity building of health systems?

In responding to this question, KII respondents recognized that the IHPB has improved health system management capacity as a whole by supporting the training and supervision of human resources, providing medical equipment, supporting infrastructure rehabilitation, assisting in procurement and supply chain management, and through integrating health information systems.

Starting especially in the second year of its implementation, the IHPB has trained a significant number of managers and health service providers. Service providers acknowledge having increased their capacity with reference to the concept of integration and on other technical areas (i.e., HIV, malaria, reproductive and maternal and child health) discussed earlier in this report. The project’s provision of job aids associated with all technical areas supported by the project was cited by respondents as representing an important contribution to the improvement of health systems. For a country with severe constraints associated with the delivery of quality health care, the importance of IHPB’s assistance was acknowledged by all respondents. In addition, the project’s support on supply chain management was cited as having contributed to the observed limited amount of stock-outs in sites visited by the evaluation team.

In support of increased access to services and of reliable diagnoses and effective integrated care, the project’s provision of a wide range of equipment has demonstrably allowed health facilities to strengthen their health systems’ ability to improve the quality of their services. A list of such equipment would include, inter alia, incubators for newborns, oxygen condensers, gynecological examination matériel, electrical and mechanical aspirators, kits for removing IUDs, refrigerators, and beds and mattresses.

2.2 In what way has the IHPB contributed to capacity building of HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services?

As discussed earlier in this report, the project’s emphasis on increasing skills of health service providers through training and through the provision of job aids and technical guidelines has been recognized by all health service providers as contributing to the capacity of services to provide quality care. At the same time, respondents have noted that the project’s training of limited numbers of health providers coupled with the reported turnover of staff significantly undermines prospects for maintaining standards of care following the project’s completion.

With reference to health system strengthening in the testing, counseling, and care and treatment of HIV, IHPB data indicates that, in Year 2 (Y2), 48 health service providers were trained in HIV testing techniques and 145 service providers were trained in HIV counseling techniques. In Y3, 501 health workers successfully completed an in-service training program in HIV. In discussing their training, the evaluation’s informants universally agreed that training had led to an improvement in the health system’s response to under-self-reporting and to an increase in the number of persons opting for early counseling and care. At the same time, health
center service providers observed that enhancing the capacity of health centers to effectively respond to the need for HIV diagnosis, care, and treatment at their level in the system has reportedly resulted in the reduction of patient loads at hospital level and to the concomitant increase in the capacity of hospitals to respond to more advanced requirements for care. In addition, improvement in capacity associated with CD4 count testing and with measuring viral load has improved the capacity of the health system to respond to the needs of PLHIV. On this issue, FGDs indicate that, prior to the project, it had been difficult for the health system to assess the need for changes in client treatments in case of treatment failure associated with changes in CD4 counts. Also, project support for locations within the health care delivery system where PLHIV can more readily receive required diagnosis and care has enhanced PLHIV access to appropriate and timely levels of care. With reference to PMTCT, health center respondents consistently expressed their support for the importance of IHPB’s training associated with promoting the administration of ART for HIV-positive women and their newborns after delivery. Finally, in responding to the national laboratory’s technical difficulties in providing timely PCR testing dedicated to early infant diagnosis of HIV, the IHPB contracted in July 2016 with a private laboratory to provide EID testing. While IHPB informants have reported that Y2 results for improved levels of EID testing were not encouraging, these same informants have reported that results for Y3 were significantly greater, especially in Kirundo province.

**With reference to health system strengthening in the prevention, care, and treatment of malaria,** IHPB records indicate that 558 health service providers were trained in malaria-related themes in Y2 while 326 were similarly trained in Y3. Nevertheless, according to UNICEF’s Humanitarian Situation Report for 2016, “...malaria cases reported in 2016 [in Burundi] are more than double those reported in the same period of 2015...” Nevertheless, the evaluation’s informants have credited the IHPB’s training and provision of guidelines on intermittent preventive treatment of malaria in pregnancy as a positive first step in stemming the tide of increased malaria cases. In addition, the provision of CCM kits for CHWs has enhanced the system’s ability to provide early diagnosis and treatment for malaria, to reduce the amount of time that caregivers are required to devote to medical care, and to provide health care providers with more time to respond to diseases that require more technical skill.

**With reference to health system strengthening in family planning,** IHPB records indicate that 78 health service providers were trained in modern contraceptive technologies in Y2 while 303 health service providers successfully completed an in-service training in RH/FP. As with other project initiatives, project support devoted to strengthening health systems’ ability in the provision of family planning services was similarly focused on capacity building and on the provision of guidelines. With reference to family planning, the project’s contribution to health system strengthening is most apparent at the level of health centers where service providers report that they have acquired enhanced skills in the insertion of IUDs and implants. In addition, FGDs with clients have recorded a significant level of appreciation for the project’s support of community-based initiatives, including CHWs’ distribution of pills and condoms and the insertion of implants by visiting health centers’ health promotion technicians (**techniciens de promotion de la santé** or TPS).

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With reference to health system strengthening in maternal and child health, IHPB records indicate that, in Y2, 171 health service providers were trained in technical aspects associated with MNCH while, in Y3, as noted above, 303 health service providers successfully completed an in-service training in RH/FP. In discussing these project training outputs, the evaluation’s respondents commonly cited two examples of ways in which the IHPB project contributed to health systems strengthening:

- Active management of the third stage of labor: From the perspective of health providers, IHPB’s technical assistance in promoting AMTSL technical directives during deliveries has reportedly contributed to the health systems’ ability to reduce appreciably maternal and infant mortality.

- Improved adherence to child immunization schedules: The project’s training of CHWs to better understand ways in which to promote clients’ maintenance of their children’s immunization schedules enhanced their health systems’ ability to reduce infant morbidity and mortality associated with diseases for which immunizations are available.

**IHPB's Strengthening of Civil Society Organizations**

In March 2016, FHI 360, the umbrella organization responsible for managing the IHPB, submitted a report to USAID\(^8\) to document the project’s two-year progress in developing the organizational and technical capacity of three Burundian civil society organizations—Association Nationale de Soutien aux Séropositifs et aux malades du SIDA (ANSS), Society for Women Against AIDS in Africa Burundi (SWAA-Burundi) and Réseau Burundais des Personnes vivant avec le VIH/SIDA (RBP+). As a project deliverable, the objective of the IHPB was to work toward transitioning the three organizations from IHPB-budgeted support to an organizational and technical position where they would be capacitated to receive direct USAID funding under future technical assistance contracts. Based on the project’s evaluation carried out in late 2015, the IHPB’s March 2016 evaluation report on the three organizations level of organizational and technical capacity concluded that each of the three would have sufficient capacity to transition and manage USAID-funded future technical contracts.\(^9\)

During the GH Pro evaluation team site visits to two of the CSO’s health facilities (SWAA Muyinga and ANSS Kirundo), FGDs with health service providers mirrored those reported upon earlier in this report: IHPB’s support led to increased effectiveness in integrating the provision of family planning methods with MNCH services; technical assistance in advocacy and community mobilization contributed to strengthening the bridge between the health services and the community; and guidance on ways to respond to GBV reportedly assisted service providers in providing more effective assistance to GBV victims. At the same time, faced with what was viewed as an abrupt termination of their contract with IHPB on December 31, 2015 and its impact on equipment provision/maintenance and on-site technical support, the two respondents from the SWAA health center in Muyinga noted that much of the quality of services achieved under the IHPB would be unsustainable.

With reference to assistance provided to develop the three CSOs’ organizational capacity, the IHPB’s quarterly and annual reports and documentation provided by IHPB indicate that the

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\(^8\) Local Partner Transition Report, FHI 360 and Core Project Partners, March 15, 2016

\(^9\) Ibid.
project’s support to the CSOs centered on strengthening six organizational components: legal structures; financial management and internal control systems; procurement systems; human resource systems; project performance management; and organization sustainability. Based on FHI 360’s 2016 CSO transition report cited above, all three CSOs achieved a Non-US Organization Pre Award Survey (NUPAS) scoring of at least 3 out of a possible 4 points except in the case of ANSS and its scope of 2.63 points for its progress on project performance management. Finally, based on FHI 360’s reported overall NUPAS scoring of 3.38 (ANSS), 3.49 (RBP+), and 3.06 (SWAA Burundi), it would appear all three CSOs meet the NUPAS criteria necessary for them to transition to direct contracting with USAID.

In support of FHI 360’s evaluation findings that the three CSOs were well-placed for transition to direct USAID contracts, the GH Pro evaluation team’s FGDs with each of the CSOs indicated that all three CSOs had gained increased levels of knowledge and expertise in being able to respond to USAID standards with reference to financial management and procurement, organizational management, and ethics compliance. At the same time, all three CSOs reported that additional technical assistance in monitoring and evaluation, human resource management, and internal auditing was still required if they were to operate effectively and independently as direct USAID contractors. Finally, from a process perspective, all three CSOs expressed the need for additional training in project design and in responding to USAID’s rigorous English language project reporting requirements.

2.3 With reference to the IHPB, have there been any barriers to the ability of the IHPB to capacity building of health services and systems? If so, how would you describe these barriers and their impact, actual or potential, on the project’s execution?

In its execution of the project, the IHPB continues to face significant constraints in its ability to appreciably strengthen the capacity of health services and systems. From the evaluation respondents’ perspective, a listing of such constraints would include, inter alia, the following principal issues:

- **Insufficient quantity of professional staff**: Because of the health system’s chronic and widespread shortages of professional grade service providers, the project was generally unable to train more than one service provider per health center.

- **Staff turnover**: Despite the IHPB’s reported adherence to its training targets, the evaluation’s respondents reported that service providers trained by the IHPB frequently leave the IHPB’s targeted health center due to attrition or transfer. As a result, gains achieved within the health system, especially with reference to integration of health services, are typically diminished.

- **Conflicts in agendas**: As discussed during evaluation sessions with IHPB staff, the project’s ability to maintain, much less increase, its training of district staff and its joint supervision output and to thereby strengthen a district’s health system has been

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11 NUPAS is a methodology developed by USAID to assist prospective offerors in determining an applicant’s suitability for awards (USAID, January 2016).

12 *Ibid*: A NUPAS scoring above 2 but below 4 indicates that “...although a control weakness was noted, compensating controls and other factors exist to reduce the residual risk within the organization to acceptable levels.”
significantly constrained by district supervisors’ availability for training or supervision due to competing agendas for their time. From the perspective of district-level officers, this acknowledged constraint was exacerbated by the project’s limited emphasis on participatory collaboration in district-level planning exercises. This constraint was reportedly most evident in the case of hospitals for which limited attention was paid by the project to responding to the capacity-development needs of hospitals.

- **Limited basic infrastructure:** While clearly beyond the IHPBS’s technical focus, the health system’s ability to take advantage of IHPB’s technical interventions continues to be negatively impacted by the health system’s chronically substandard infrastructure and its widespread and limited access to electricity and water. In addition, the health system’s inconsistent access to a reliable source of blood supply, especially in the case of anemia related to malaria, was cited by both service providers and IHPB technical staff as having a negative impact on the health system’s ability to provide comprehensive care for its clients.

- **Curtailment of project support for HIV interventions in Muyinga and Karusi provinces:** While beyond the capacity of the project itself to address, PEPFAR’s decision to suspend support for HIV activities was repeatedly cited by the evaluation’s respondents as an obstacle to the health system’s ability to continue to respond to HIV priorities within these two provinces. Documentation associated with this regrettably abrupt decision indicates that PEPFAR’s decision to withdraw support for HIV activities was based on the agency’s policy decision to focus on Burundi’s five provinces with the highest burden and highest yield for HIV.

- **Religious-based barriers to family planning:** In a significant number (38%) of sites surveyed during the evaluation, religious barriers to the provision of modern contraceptive methods was observed to have an obviously negative impact on the health system’s ability to introduce family planning in these affected institutions. Discussions with health service providers and with CHWs allied with religious institutions indicated that clients desiring modern contraceptive methods were occasionally—but not systematically—referred to health centers that were not religiously affiliated. Nevertheless, it is the opinion of one member of the evaluation team that the disparity in availability of modern family planning methods can only be addressed through central-level policy change.\(^{13}\)

- **Rumors about family planning:** In addition, the evaluation’s respondents cited prevailing rumors associated with family planning as having an impact on the health system’s ability to promote utilization of modern family planning methods.

- **Limited emphasis on data for decision-making purposes:** While the project devoted a significant level of effort toward assisting health centers in the collection and transmission of service delivery data, discussions with health center managers and a

\(^{13}\) In 1978, the team lead for this evaluation was responsible for assisting the Government of the Kingdom of Lesotho in developing a national policy focused on providing nation-wide client access to modern contraceptive methods. As a result of this initiative, the government, in negotiations with religiously-affiliated institution, issued a policy that those institutions that could not offer modern family planning methods would agree to the government’s providing clients with modern family planning matériel in a nearby FP “kiosk.”
review of project quarterly and annual reports indicated that emphasis on the use of data for decision-making purposes was focused on providing summary briefings at district level rather than on providing health center managers with an in-depth understanding of ways in which data specific to their facilities could be used to improve the quality of services offered by their institutions.

**Question 3: How well is the integration of health services approach working in the covered area?**

**Introduction:** In addressing Question 3, the evaluation team’s findings are based on a qualitative analysis of responses to the following four sub-questions, each of which was addressed during the team’s standardized KIIs with 57 respondents in the 12 districts included in the four IHPB provinces: Karusi, Kayanza, Kirundo, and Muyinga.

3.1 How would you define integration and its importance to improved HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services at patient diagnosis and treatment and at management levels?

3.2 To what extent has the program been effective in integrating HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services at patient diagnosis and treatment and at management levels? In what way could collaboration be improved among services and in-service management?

3.3 What has been the impact of this program integration?

3.4 What steps should be taken in the future to increase effective integration of HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services at patient diagnosis and treatment and management levels?

3.1 How would you define integration and its importance to improved HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services at patient diagnosis and treatment and at management levels?

In responding to this first sub-question, key informants generally concluded that integration can be defined as **an approach that allows us to address needs in a global way.** Expanding on this definition, informants agreed that, for the patient, integration is a way to get everything necessary in one visit to the health service. From its perspective, IHPB has defined integration as “... (1) services delivered together at the same time by the same health provider; (2) services delivered together at the same facility/same community by referral to a different health provider; or (3) referral of clients to another provider another day in the same facility or a different one depending on needs.”

3.2 To what extent has the program been effective in integrating HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services at patient diagnosis and treatment and at management levels? In what way could collaboration be improved among services and in-service management?

IHPB’s reporting on its current progress against its Monitoring and Evaluation Plan provides insufficient detail to determine the extent to which service providers have been actively trained in integration. Based on the evaluation’s on-site review of supervision registers, (please see

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14 Communication from IHPB to the GH Pro Evaluation Team, December 2016.
Table 2), it does appear that IHPB’s visits were dedicated to providing supervision on specific interventions rather than on promoting ways in which overall integration of interventions could be enhanced.

However, at hospital and health center levels, key informants confirmed that IHPB training, as opposed to post-training supervision, was effective in promoting integration through provider-initiated testing and counseling for HIV in ANC and other maternity-related services. Key informants also confirmed that the integration of provider-initiated HIV testing and counseling (PITC) with antenatal care (ANC) services has had a positive effect on the reduction of stigmatization and discrimination in the delivery of services. Similarly, key informants have confirmed that the project’s training on the promotion of IPTp for malaria during early stages of ANC and of family planning following deliveries has effectively introduced both initiatives at important stages in the service delivery process.

At the same time and with reference to challenges to integration now and in the future, as a consistent theme among informants at hospital and health center levels, respondents noted that the provision of integrated services remains largely vertical due to health services’ limitation in personnel and heavy patient workloads. However, while health centers continue to maintain a daily calendar focused on the provision of a specific service, such as pre-natal care or immunizations, service providers have recognized the potential that integration represents in terms of clients’ ability to receive a packet of services during a single visit. Nevertheless, during the evaluation team’s site visits, it was evident that integration of services, while accepted by service providers as an important concept for the future, is not yet a working organizational or management concept at either hospital or health center levels. In addition, in a significant number of hospitals and health centers, the evaluation team found that the integration process is insufficiently documented, a finding that suggests that, for the purposes of sustainability, the IHPB should address ways in which to ensure that health center staff have a knowledge base with which to develop a more inclusive approach to integration. Finally, in a significant number of hospitals and health centers, the evaluation team found that the integration process is insufficiently documented, a finding that suggests that, for the purposes of sustainability, the IHPB should address ways in which to ensure that health center staff have a knowledge base with which to develop a more inclusive approach to integration.

Despite these challenges to full-scale integration, FGDs with service providers indicated that the IHPB was reportedly highly effective in promoting the benefits of integration. According to many respondents, the project’s introduction and assistance in designing ways in which to further integrate services and orient clients through training provided to CHWs resulted in a more comprehensive response to the needs of clients. At the same time, health service providers report that clients do not fully accept the concept or the benefits of integration. For example, it was reported that pregnant women often refuse to take preventive treatment against malaria. Accordingly, health service providers suggested that the project assist the health services in providing an information/education program for clients.

In addition, during FGDs with CHWs, it was evident that they had a firm grasp of the importance of integration. As strong proponents of the benefits of integration, CHW informants cited numerous examples in which integration of health services had promoted the quality of life for their community-based clients. Among the examples of ways in which integration had
improved the access to tools to allow for their communities to engage in the practice of healthy behavior, CHWs cited the testing for HIV and IPTp for malaria, the distribution of mosquito nets during ANC, and the promotion of family planning in maternities following deliveries.

In responding to questions on the effectiveness of integration initiatives introduced by IHPB, the 33 CHW focus group participants were universally positive in their appraisal of the project’s promotion of health centers’ integration of HIV testing and provision of care as part of initial antenatal visits. In addition, the project’s linkage of health centers’ integration of IPTp with ANC visits helped set the stage for the CHWs own community-based prevention and care for malaria or PECADOM (Prise en charge à domicile or home-based management of malaria). Similarly, health providers’ integration of the provision of Depo-Provera® (depot medroxyprogesterone acetate, or DMPA) for family planning with other health care needs (such as monitoring for malnutrition for children under five years of age) reinforced the CHWs’ own legitimacy as health care extension agents.

Despite the CHWs’ positive assessment of IHPB’s promotion of integration, CHWs voiced concern over the fact that they regularly face shortages of drugs, especially for the prevention and treatment of malaria. As a result of such periodic shortages, a significant number of CHWs commented that, faced with such shortages, they experience a reduction in their technical capacity in relation to their knowledge about correct drug dosages.

From the onset of the evaluation team’s FGDs with clients, it was evident that it would be difficult to maintain the same level of informed discussion as the team had experienced with other more knowledgeable informants. In addition, the fact that many of the clients visit a health facility when they are not in the best of health necessarily limited the evaluation team’s access to clients. Despite these constraints, the evaluation was able to hold six client focus groups in which 33 clients participated. During the focus group process, clients were unfailingly patient and universally exhibited interest in the discussions.

When asked to identify positive aspects of care provided through the integration of services, clients cited their appreciation for the promotion of integrated services especially with regard to the availability of free testing for HIV during ANC visits. They also expressed their support and appreciation for the provision of free maternity services and for the attention provided to children less than five years of age. Finally, several clients noted that when they visit a health center for immunizations, they are given a briefing on family planning while they wait for their immunizations.

3.3 What has been the impact of program integration?

From the KII perspective of senior hospital staff, integration has changed the diagnostic and care process of service providers from one that focused on a single health issue to one that focused on providing a client with the opportunity for diagnosis and care for multiple health issues. As a result, according to senior staff, the mentality of both providers and clients appears to be shifting, despite continuing pockets of provider and client resistance, to an understanding and acceptance of the importance of integration. As cited by senior staff, a prime example of the impact of integration was, thanks to the integration of HIV testing during initial ANC visits, the reported increase in the identification of HIV sero-positives, and the subsequent enrollment of these clients in HIV counseling and care.
From the KII perspective of senior health center staff, integration of services has resulted in the reduction of time spent by clients on repeat visits to a health center and in an increase in early ANC consultations reportedly due to the clients’ knowledge that free HIV testing would also be available. A somewhat unexpected but credible result of integration was the informants’ belief that the acceptance of community-based provision of condoms and pills for family planning—and the strengthening of the role of the CHW—was due to clients’ initial introduction to the importance of family planning following deliveries and during well-baby visits at health centers.

Supporting the above senior staff assessment of the impact of integration, health center staff participating in FGDs also cited the provision of IPTp during ANC visits and the concomitant decrease in malaria and in child mortality as a direct impact of integration of these two services. It was also noted by respondents that in those health centers in which integration is proactively promoted, clients, during a single visit, have the potential of the opportunity to receive curative care; to be tested for HIV; to receive, if appropriate, counseling and care for HIV; and to receive family planning counseling and services. It is in such instances that health center staff recognized that the full impact of integration could be fully realized.

However, despite the evidence that there was a significant degree of understanding associated with the potential impact of integration, the evaluation team did not observe any health facilities in which the full-scale program of integration of all potential services was a standard practice. Indeed, in most cases, the application of integration was province specific: in Karusi Province, emphasis was placed on integrating family planning and HIV; in Kayanza Province, emphasis was placed on integration of family planning in maternal health and HIV services; in Kirundo Province, emphasis was placed on integration of antenatal care, GBV services, screening for malnutrition and HIV testing; and in Muyinga Province, emphasis was placed on integration of PMTCT and malaria management. Reasons cited for the project’s challenges associated with integrating services in health centers included: (i) shortages in the number of personnel available to provide services; (ii) the limited number of personnel trained in integration; (iii) personnel attrition; (iv) the sheer volume of clients requesting services; and (v) “...smart integration opportunities that can primarily contribute to the achieved of the contractually-defined mandatory results.”

From the perspective of CHWs, the major impact of integration has been the change in mentality toward health services within the community. Prior to the project’s interventions, health centers were viewed as places to go to seek curative care. Now, according to the CHWs, this prevailing attitude among clients and service providers is gradually shifting toward an appreciation of the role of both the CHW and the health center staff as agents of something approaching wellness combined—or integrated—with care. Toward that end—i.e., a change in mentality—IHPB’s training of CHW as agents of change, according to CHWs themselves, has been a major factor. Despite this positive movement toward more comprehensive services, the CHWs included in the evaluation’s FGDs continue to believe that there are too few health center personnel, that the emphasis on curative services remains paramount, and that the health centers have not yet succeeded in reducing the time required for clients to receive services.

15 IHPB communication to GH Pro evaluation team, December 2016.
3.4 What steps should be taken in the future to increase effective integration of HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services at patient diagnosis and treatment and management levels?

At the management level, KIIIs with district medical officers indicated that the application of effective integration could be enhanced by IHPB’s efforts to enhance district-level ownership of the goals and objectives of integrated services. Despite IHPB annual and quarterly reports to the contrary, district-level officials expressed concern with the project’s limited effectiveness in engaging district staff in planning exercises. Indeed, the prevailing attitude among district staff was that the IHPB’s planning was imposed upon them with limited attention directed toward a district or health services’ actual needs or capacities. As an alternative approach to project planning, district-level officials suggested a more participatory approach to joint planning exercises during which goals, objectives, and activities could be openly discussed and jointly developed.

During hospital-based KIIIs, senior staff indicated that project supervision should focus more directly on ways in which hospitals and health center staff can enhance the effectiveness of integration. Closely aligned to this suggestion was the health center senior staff’s recommendation that more attention be directed toward on-site training on integration for all health providers. In addition, it was suggested by health center staff that the IHPB develop an informational handout in Kirundi—in the form of a postcard—that could be used both by health center staff and by CHWs to promote clients’ understanding and support for the focus of an integrated approach to the provision of health services.

Finally, with reference to the IHPB’s emphasis on the health center’s collection and forwarding of data to document the project’s progress toward defined indicators, health center staff suggested that they be provided with feedback on the project’s analysis of the forwarded data. It was further suggested that such feedback—in the form of an analysis of data for decision-making purposes, would upgrade each health center’s capacity to identify and respond to its challenges associated with service delivery and with missed opportunities to promote the effective integration.

**Quantitative Analysis of IHPB’s Performance**

As discussed in the previous paragraphs and as specified in the scope of work’s four qualitative questions, much of the evaluation’s emphasis was placed on gaining the field perspective of service providers and clients with reference to the quality of IHPB’s performance. In the interest of expanding upon the evaluation’s qualitative findings, the evaluation team also undertook a quantitative analysis centered on two additional questions that were not included in the assignment’s scope of work:

1. To what extent does the IHPB’s reporting on Year 3 on its performance and evaluation plan provide insight on its progress toward meeting requirements associated with its principal performance indicators?

2. To what extent do on-site observations validate IHPB reporting on its progress in supporting technical interventions introduced by the project’s technical team?
Findings associated with the above two questions are discussed on the following paragraphs.\textsuperscript{16,17}

**Findings associated with an analysis of IHPB’s Year 3 Performance Monitoring and Evaluation Plan**

In documenting the project’s response to mandatory indicators incorporated in its 2015 Y3 monitoring and evaluation plan, IHPB’s records provide performance data on 73 (97\%) of the PMEP’s 75 Y3 indicator targets. As indicated in Table 1, of the 73 PMEP indicators with recorded Y3 results, the project reported that it had achieved 100–150\% of its targets for 25 (34\%) of 73 PMEP indicators. In addition, the project reported that it had achieved greater than 150\% of its targets for 18 (25\%) of the 73 PMEP indicators. Moreover, for those 43 indicators for which the project had achieved at least 100 percent of Y3 targets, the level of achievement against these indicators ranged from 100–411\%, with a mean of 146\% achievement of targets and a median of 120\% achievement of targets.\textsuperscript{18}

Table 1. IHPB Performance Evaluation: Indicator Analysis – Year 3 (Y3)

<table>
<thead>
<tr>
<th>Number of Indicators with Y3 targets</th>
<th>Percent of Indicators with Y3 results</th>
<th>Score Card on Y3 Targets Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent of indicators with &lt; 50% of Y3 Targets Achieved</td>
<td>Percent of indicators with 50 - 75% of Y3 Targets Achieved</td>
</tr>
<tr>
<td></td>
<td>75</td>
<td>97%</td>
</tr>
</tbody>
</table>

For the 73 Y3 PMEP indicators for which results were provided, the IHPB reported that, for 32\% (23) of the PMEP indicators, the project had achieved between 76\% but less than 99\% of their targets, with an average and a median of 87\% of their indicated targets. Finally, in only seven (9\%) of all 73 targets for which results were reported for Y3 targets did the IHPB achieve 75\% or less of Y3 targets.

In the evaluation team’s discussions and communications with the IHPB concerning the reasons for the clear over-achievement of progress against established targets, unanticipated demand for additional support in technical areas—such as Number of community health/para-social workers who successfully completed a pre-service training program—MNCH (246\% of Y3 targets) reportedly led to the project’s having significantly exceeded many of its established targets. At the same time, as discussed in this report’s recommendations, the evaluation team’s site visit discussions as well

\textsuperscript{16} Please note that the analysis presented in Table 1 is based on the IHPB’s submission of 2015 PMEP attainment of targets is based on information that was obtained on December 5, 2016 after the evaluation team concluded its in-country evaluation on October 6, 2016.

\textsuperscript{17} Please note that data sets used in the qualitative analysis of PMEP reporting data and on data obtained during the evaluation’s on-site visits to 23 IHPB client sites are available upon request.

\textsuperscript{18} In the evaluation team’s discussion with IHPB on why so many targets were over-achieved, unexpected demand was cited as the major reason for much of the excess achievement. Moreover, as the major focus of the evaluation was qualitative in nature, it was beyond the scope of this evaluation to explore or comment in more detail on the quantitative analyses provided in the report.
as our on-site observation would suggest that the project and USAID would benefit from a joint
discussion on ways in which to re-assess how targets could be established in the interest of
arriving at more realistic targets for the project’s remaining two years.

**Findings associated with on-site observations**

In responding to the evaluation’s first questions, the evaluation team carried out on-site
observations in each of the 23 facilities visited during the evaluation’s two weeks in the field.
The standardized framework for the on-site evaluations (see Annex C) including observations on
the following items:

1. Were IHPB-supplied job-aides and technical guidelines readily available?
2. Was there evidence of drug stock-outs?
3. To what extent were modern contraceptive methods offered?
4. During the last 12 months, was there evidence of IHPB-supported supervision related to
   the project’s five technical areas?
5. Was IHPB-supplied equipment functional?

**Table 2. IHPB Evaluation – On-Site Observations**

<table>
<thead>
<tr>
<th>1. Average availability of IHPB-provided job aides across 22 facilities</th>
<th>68% availability of all job aides</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Evidence of stock-outs</td>
<td>27% of facilities had evidence of stock-outs at the time of the site visits</td>
</tr>
<tr>
<td>3. Average availability of five principal modern family planning methods</td>
<td>64% of surveyed facilities offered client access to modern FP methods</td>
</tr>
<tr>
<td>4. Percent of facilities with supportive supervision visits during the last twelve months</td>
<td>Malaria</td>
</tr>
<tr>
<td></td>
<td>50%</td>
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</tbody>
</table>

As indicated by Table 2:

1. On average, 68% of nine IHPB job aids and technical guidelines were available across the
   22 sites visited by the evaluation team. With reference to specific job aids or technical
guidelines:
   a. More than 90% of all surveyed facilities were observed as having readily available
      ART technical guidelines; PMTCT technical guidelines; and technical guidelines on
      case management of diarrhea, and SOPs for the testing and treatment of HIV.
   b. 64% of all surveyed facilities had readily available technical guidelines on PEP.
   c. 59% of all surveyed facilities had readily available access to BEmOC algorithms.
d. Fewer than 50% of all surveyed facilities had ready available access to laminated guidelines on IPTp; algorithms on IPTp, and an IHPB-supplied and updated QI wall chart.

2. During the site visits, it was observed that 27% of surveyed facilities had documented drug stock-outages. However, in discussions with personnel responsible for drug supply maintenance and based on a rapid review of stock records, it did not appear that there were any systemic or long-term shortages in essential drugs thanks to support on drug supply provided by other assistance projects. Moreover, in discussions with these same personnel, IHPB’s technical assistance in drug supply management reportedly led to the health facilities’ ability to identify and respond to potential stock outages.

3. Among those facilities surveyed, 15 (64%) offered varying levels of availability of the full array of possible modern family planning methods, including pills (64%), injectables (64%), male (64%) and female (50%) condoms, IUDs (55%) and implants (41%). In addition, 14% of surveyed facilities (the majority of which were hospitals) were equipped to provide vasectomies and tubectomies. In addition, among the 23 surveyed facilities, eight (36%) were religiously-affiliated. Among these facilities, none offered any modern contraceptive methods. In all such facilities, clients were reportedly counseled on natural family planning through the use of cycle beads (colliers du cycle) for the control of pregnancy during periods of high fecundity.

4. With reference to IHPB-supported supervisory visits to the surveyed facilities during the last 12 months, supervisory registers indicated that 50% of the facilities were provided with supervision related to malaria, MCH, and HIV/AIDS while 44% of surveyed facilities were provided with supervision related to MNCH and 38% of surveyed facilities were provided with supervision related to RH/FP.

5. Finally, in assessing whether IHPB-supplied equipment was functional, the evaluation team was unable to verify by direct observation whether all IHPB-supplied equipment was functional at the time of the visit. Nevertheless, discussions with health center managers indicated that all such equipment was reportedly in working condition. In an effort to validate the health facilities’ self-reporting on the functionality of IHPB-supplied equipment, the evaluation team assessed, through observation and through asking the health center managers to demonstrate equipment functionality, whether the first two items on a facility’s list of IHPB-supplied equipment were indeed functional. In all cases, the evaluation team determined that all assessed equipment was in working order. At the same time, it was reported that, in instances where facilities lost electrical power, equipment that depended on the availability of electricity were rendered non-functional.
IV. CONCLUSIONS

In this report’s discussion of findings, the evaluation team has identified a significant number of strengths associated with the evaluation’s central focus: To assess progress that the Integrated Health Project Burundi (IHPB) has made to date in achieving its objectives and document the effectiveness of the project’s approaches and responsiveness to integrating and improving health behaviors, services and systems. At the same time, the evaluation team has identified a number of challenges that remain to be addressed if the IHPB is to maintain its progress toward responding to the project’s central focus: To increase capacity to deliver quality integrated health and support services and communications and behavioral interventions. In summary, a list of the IHPB’s major strengths as well as its challenges identified during the evaluation would include the following items:

Strengths

- Integration represented an important contribution to the improved quality of services.
- Equipment provided by the project enabled the health centers and hospitals to provide new services.
- The improvement of community-based health services contributed to the development of a bridge between the communities and their health centers.

Challenges

- Personnel trained and supervised by the project were too few in number to provide realistic expectations that the government will be able to sustain the project’s progress in promoting effective integration of services.
- Limitations in the number of health center staff and in the health centers’ basic infrastructure continue to impact negatively on the IHPB’s progress on introducing integration as a means of promoting quality health care.
- The project’s limited success in facilitating effective joint planning with hospitals and districts is a challenge that, if addressed during the project’s remaining two years, can make a significant contribution to expectations of sustainability following the project’s completion in December 2018.

In addition, when viewed from a forward-looking perspective, Figure 2 illustrates the evaluation team’s analysis of Strengths and Weaknesses, Opportunities and Threats (SWOT) associated with the project’s implementation during its remaining two years and with USAID’s possible support for a future project.
Figure 2. Analysis of Strengths, Weaknesses, Opportunities, and Threats associated with the IHPB Project (Internal) with a possible Future Project (External)

<table>
<thead>
<tr>
<th>Positive Internal Strengths Associated with the IHPB’s Remaining Two Years</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality of Training</strong>: Based on discussions with health service managers and with health service providers and community health workers, the quality of training provided under the IHPB has been of a high-quality standard.</td>
</tr>
<tr>
<td><strong>Behavior change by the service provider and by clients</strong>: Reported and observed positive behavior change regarding the promotion of integration (among service providers) and the increased utilization of services (among clients).</td>
</tr>
<tr>
<td><strong>Increase in key indicators</strong>: Key indicators, such as the reduction in maternal mortality, especially associated with at-risk deliveries, increased timely testing for HIV, and the timely provision of malaria prophylaxis at early stages of pregnancy are among those indicators that hold promise for continued improvement during the project’s remaining two years.</td>
</tr>
<tr>
<td><strong>Linkages between communities and health centers</strong>: In large part due to IHPB’s training of community health workers, the evaluation team noted a reported increase in communities’ understanding of the health centers’ role in contributing to clients’ health status and their quality of life.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Negative Internal Weaknesses That Should be Addressed During the IHPB’s Remaining Two Years</th>
</tr>
</thead>
</table>
| **Continued resistance to integration among some service providers and clients**: Despite the noted impact of integration upon the quality of clients’ health outcomes, resistance to full application of integration was noted among some service providers who perceived integration as being an added burden to their already heavy workloads. In addition, some resistance to integration was noted among clients who perceived application of
the initiative as negatively prolonging the time required to receive care for their immediate health concerns.

- **Vertical nature of technical assistance**: As noted earlier, IHPB’s practice of viewing the provision of technical training and supervision from a vertical, disease-specific perspective is a project weakness that, unless addressed during the project’s remaining two years, will continue to undermine the project’s ability to promote the benefits of integration.

- **Limited emphasis on the importance of gender-based violence**: Although included as an IHPB initiative, the effectiveness of training and supervision dedicated to responding to the psychological and physiological manifestations of GBV continues to be limited and unresponsive when measured against the prevalence of GBV among clients and within communities.

- **Inadequate process-oriented documentation**: Although the IHPB responded credibly to the need for technical documentation, little documentation exists that will enable the project to assist district, provincial, and national government officials in understanding the process required to promote effective integration.

- **Excessive emphasis on training as opposed to supervision**: Due in large part to the IHPB’s need to respond to contractually dictated training targets and to the project’s delayed start in responding to those targets, the importance of supportive supervision continues to be inadequately addressed. As a result, capacity gained through training risks being undermined without increased attention being directed toward on-site support of those who have been trained.

**POSITIVE EXTERNAL OPPORTUNITIES ASSOCIATED WITH A POSSIBLE FUTURE PROJECT**

- **General acceptance of integration’s importance by the Government of Burundi**: Although a future project will need to devote a significant amount of effort toward strengthening the government’s commitment and support to nationwide application of integrated health services, the evaluation’s respondents have reported that government support of the importance of integration is no longer in doubt.

- **Decentralization to districts for the management of health services**: In addition to the positive opportunity for the future represented by the Government of Burundi’s general acceptance of the importance of integration, Burundi’s decentralization policy has resulted in an appropriate shift to districts of the responsibility for managing health services. This shift in responsibility represents a positive opportunity for a future project to continue IHPB’s emphasis on providing hands-on technical assistance to health systems’ administrative/management units most directly implicated in supporting and strengthening health services’ quality of care.

- **Potential value of performance-based financing (PBF)**: The concept and application of PBF has gained considerable technical traction in disparate political environments as a means of positively impacting health outputs and outcomes through direct compensation of service providers for attainment of defined service delivery indicators. Given Burundi’s general acceptance of the benefits of PBF, and given the current political
and economic environment, it appears that support of a managed approach to PBF would represent an opportunity to elevate service providers’ commitment to the goal of enhanced integration of health services.

- **Solid reputation of USAID health projects**: From the perspective of many of the evaluation’s respondents, USAID health projects in Burundi have attained a strong reputation for excellence in management and for quality technical assistance. In building on this general reputation and on that of the IHPB, a future project should be able to count on the cooperation of the government and on the interest and support of future beneficiaries of USAID technical assistance to Burundi.

**NEGATIVE EXTERNAL THREATS ASSOCIATED WITH A POSSIBLE FUTURE PROJECT**

- **Limited government budget for health**: Continued low levels budget support for health will negatively impact a future project’s ability to effectively sustain and enhance IHPB’s progress on improving the quality of services through integration.

- **Limited personnel at health center (centre de santé or CDS) level**: Similarly, without some effort to increase the limited allocation of personnel to health centers, a future project’s ability to maintain and extend the IHPB’s progress in promoting integrated services will be significantly compromised.

- **Limited basic health infrastructure**: Chronic deficiencies in CDS’ basic infrastructure represent a significant threat to a future project’s ability to introduce and support improved quality of health care.
V. LESSONS LEARNED

Evaluation Question 4. What lessons learned can inform project management for the remainder of the project life and future potential follow-on designs?

Introduction: In addressing Question 4, the evaluation team’s findings are based on a qualitative analysis of responses to the following three sub-questions, each of which was addressed during the team’s standardized KIs with 57 respondents in the 12 districts included in the four IHPB provinces: Karusi, Kayanza, Kirundo, and Muyinga.19

4.1 Looking back at the IHPB’s first three years of project implementation, what lessons have been learned that will help inform project management for the remainder of the project’s life?

4.2 Based on lessons learned and with reference to the IHPB final two years of operation, what actions or interventions would you recommend to build upon and improve prospects for the sustainability of IHPB activities?

4.3 Based again on lessons learned, if you were to be involved in the design of a project to continue after the IHPB is completed in September 2018, what would be your principal goals and objective for such a project?

4.1 Looking back at the IHPB’s first three years of project implementation, what lessons have been learned that will help inform project management for the remainder of the project’s life?

At district health officer levels, there was general agreement that, to date, the level of interaction between project officers and district managers at district-level key informants generally focused on the project’s ensuring that their project objectives were met, with minimal consideration directed toward ensuring that the districts developed the capacity to sustain activities following the project’s completion. Accordingly, district health officers confirmed that a major lesson learned was that project initiatives cannot be sustained unless there is full and effective involvement of district managers in the planning and implementation of a technical assistance project.

At the hospital level, key informants, when asked to comment on lessons learned, tended to focus on the limited extent to which the project’s interventions responded to a hospital’s needs. For example, hospital-level informants indicated that their real needs centered on basic infrastructure development and on the importance of ensuring that the hospital is equipped, both technically and materially, to function as a referral base for health centers within their areas of responsibility. Thus, from the hospitals’ perspective, a principal lesson learned was that without attention being directed toward enabling hospitals to fulfill their role as technical resources for their client health centers, there is limited expectation that the project’s technical interventions can be sustained.

From the perspective of the 16 KII participants and of 21 FGD health center participants, observations on lessons learned tended to center on more practical, day-to-day considerations. As the cadre of health workers most responsible for introducing and promoting integrated

19 Please note that actions suggested by lessons learned are integrated into Section VI: Recommendations.
services, the health center service providers were generally outspoken in stating that a key lesson learned was that integration has played a key role in changing the mentality of the population on the expanded role of the health center as a principal force for preventive health care. Similarly, health center service providers have learned that meaningful involvement of trained CHWs represents a critical component to a community’s improved standard of health care. At the same time, health center service providers have learned that, without effective and supportive supervision, any gains in their technical service delivery capacity stand a limited chance of being sustained.

4.2 Based on lessons learned and with reference to the IHPB final two years of operation, what actions or interventions would you recommend to build upon and improve prospects for the sustainability of IHPB activities?

At district health officer levels, there was general agreement that the IHPB should place a major focus on ensuring that district health officers are actively involved in planning and implementing project activities for its final two years. While district officers acknowledged that the development of a closer partnership with the districts will call for the IHPB to change their approach to project management, respondents believed that such changes were necessary to gain district support toward the goal of improving prospects for sustainability of IHPB interventions.

At hospital level, respondents called for the IHPB to focus its efforts on expanding training to those service providers, at all levels, who have not yet received the benefit of IHPB training. While this all-inclusive target, given project resources and the time remaining, is clearly unrealistic, the number of people trained, as reported upon earlier in this report, represents a fraction of those who require such training. (This constraint is addressed in this report’s Recommendations section.) In addition, hospital respondents indicated that, for the purpose of sustainability, the IHPB should ensure that its technical approach be fully documented, including a frank appraisal of constraints associated with the project’s technical initiatives. This point is also addressed in the Recommendations section.

As in the case of hospital staff, health center staff called for the project to train more personnel and to provide detailed documentation on project interventions during the project’s remaining two years. Health center respondents also recommended that the IHPB place a major emphasis on supportive supervision that will identify and respond to the need for staff to feel more confident in their ability to sustain the quality of services introduced by IHPB training. In addition, health center staff recommended that the project provide training in the periodic maintenance of equipment supplied by the project. Finally, in recognition of the importance of the role of CHWs in maintaining the communities’ quality of health maintenance, the health service providers were united in their recommendation that the IHPB work with the health centers to design and implement a CHW technical support program that will include: (1) appropriate additional training to expand their community-based service delivery capacity; (2) basic equipment (e.g., medical satchels, bicycles, gloves, raincoats, etc.); and (3) job aides, including plastic-coated medical care algorithms and multiple copies of a pocket-sized BCC-focused postcards designed to promote communities’ knowledge and support for an integrated approach to the delivery of services and to the provision of curative and preventive care.
4.3 Based again on lessons learned, if you were to be involved in the design of a project to continue after the IHPB is completed in September 2018, what would be your principal goals and objective for such a project?

At district health officer levels, the principal recommendation for a future project centered on the insistence that the district health offices be involved in all aspects of the future project’s design, implementation, and monitoring. With reference to the future project’s focus, district-level officers also recommended that the project’s components, while continuing an emphasis on integration, should be based on a participatory baseline assessment of the district’s needs.

At hospital level, in addition to recommending a baseline assessment of health service capacity-development needs, hospital officials recommended that the future project focus on extending the concept of integration to other hospital clinical services. As part of the future project’s training program, hospital officials also recommended the development of a program of continuing medical education (CME) designed to assist service providers to maintain their competency as well as to stay abreast of new and developing technologies. Finally, hospital-level respondents recommended that the future project reinforce hospitals’ capacity as reference centers for their client health centers.

At the health center level, key informants and participants in FGDs recommended that the future project, while continuing an emphasis on integration, should also continue to support and expand the role of CHWs in the promotion of communities’ health environment. Toward this end, health center staff recommended that, under the new project, CHWs be technically equipped to respond to prevalent community health concerns, such as diabetes, hypertension, parasitic worm infections, nutrition, and HIV stigma and discrimination and HIV/TB co-infection. At the same time, health center staff recommended that the new project maintain the IHPB’s demonstrated success in the prevention of malaria during pregnancies while expanding malaria outreach through the provision of mosquito nets to a wider population beyond mothers and children under five years of age, and through training and provision of medical supplies and equipment devoted to residual household spraying. In addition, it was recommended that the future project include a youth-oriented initiative with a focus on increasing knowledge and practice associated with a healthy life style. Finally, and perhaps of primary importance, health center informants recommended that the new project include an initiative that will address health centers’ chronic need for basic infrastructure development.
VI. RECOMMENDATIONS

In proposing recommendations, the evaluation team was guided by the following requirements contained in the IHPB evaluation’s scope of work:\textsuperscript{20}

\begin{quote}
FOCUS OF RECOMMENDATIONS FOR THE CURRENT PROJECT
Based on the evaluation’s purpose and the findings, describe

1. What remains to be done?
2. What changes can be made in program design or implementation to result in more effective and/or efficient execution and improved results?
3. Recommend actions and/or decisions to be taken by management.
\end{quote}

In addition to responding to the above guidelines, all of which refer to the current project, the final section of the evaluation team’s presentation of recommendations addresses, at the request of USAID/Burundi, recommendations for a possible future project. While the final recommendations address somewhat similar issues, the focus of the final recommendations is on the future, following the completion of the IHPB. As such, the final recommendations will describe:

\begin{quote}
RECOMMENDATIONS FOR A FUTURE PROJECT
4. What changes are recommended in a future program’s design or implementation that could result in more effective and/or efficient execution and in improved results?
5. What potential new solutions to problems faced by the project could be introduced in a new project?
6. What actions and/or decisions should be taken by management in a future project?
\end{quote}

In defining its recommendations, the evaluation team based its recommendations on a qualitative analysis of responses to provide by 57 KII respondents in the 12 districts included in the four IHPB provinces: Karusi, Kayanza, Kirundo, and Muyinga. At the same time, the team was guided by its observations in the field, by its review of available documentation, and by its own national and international experience in addressing issues associated with the integration of health care packages.

\section*{RECOMMENDATIONS FOR THE CURRENT PROJECT}

1. What remains to be done?

\textbf{Training of trainers:} In this report’s discussion on findings, it was noted that, contrary to IHPB project reports, the efforts to develop a cadre of certified trainers had produced little evidence that trained health center staff had developed a capacity to train additional staff from their health facilities. In addition, the findings have noted that problems of attrition and movement of staff had undermined any expectations associated with transfer of knowledge. Accordingly, it is recommended that:

\textsuperscript{20} USAID/IHPB Evaluation or Analytic Activity Statement of Work (SOW), August 18, 2016, Page 24 (see Annex A.)
• The project immediately engage an outside educational consultant to work with project technical staff and with district technical staff as a team in the definition of an intensive TOT curriculum focused on the integration of basic health services.

• Following immediately upon the development of the curriculum, the TOT team will enroll its trained health service providers in a course whose graduates will be certified as having completed the first stage of two TOT stages.

• The second stage in the TOT process will consist of a scheduled series of supervisory visits to trainees' health services during which the TOT team will work with each trainee to ensure that the TOT trainee has developed the capacity to transfer his/her knowledge to those health center staff who have not benefited from training in the IHPB’s technical areas.

• At the end of this process, which should be completed by June 2018, it is proposed that application of this recommendation will result in:
  – The development of a trained cadre of experienced trainers
  – The comprehensive training of all health center staff in the process of integrating basic health services
  – The focused strengthening of IHPB and district-level staff’s capacity in supportive supervision

• Given the fact that, for 25% of its Y3 PMEP performance indicators, the IHPB exceeded established targets by more than 150%, USAID and IHPB should work together on an analysis and re-adjustment (if indicated) of targets for Year 4 and Year 5. In doing so, all parties will have achieved a more realistic estimation of the IHPB’s potential for further advancing the project’s potential outputs for its remaining two years.

Enhanced focus on gender-based violence: In recognizing that the IHPB has introduced the topic of gender-based violence through training of service providers and through the provision of a GBV-response packet, evidence suggests that the response of these same service providers is limited in scope and impact commensurate with the acknowledged prevalence of GBV in the nation’s communities. Accordingly, it is recommended that, in the remaining two years of the project, the project continue to strengthen its effective collaboration with the USAID’s BRAVI (Burundians Responding Against Violence and Inequality) Project, especially with reference to ways in which service providers can be trained to identify and address the psychological impact of attacks upon women in addition to providing care for the more apparent external manifestations of the results of gender-based violence.

Enhanced support for community health activities: In this report’s discussion of findings, the reported and observed importance of the role of CHWs figured prominently in the IHPB’s positive promotion of integration. Accordingly, this report recommends that the IHPB undertake an immediate and rapid assessment of ways in which it can further enhance CHW’s capacity to work more effectively with their communities. While it is anticipated that this rapid assessment will identify a number of ways in which the project can respond to the knowledge-based development needs of CHWs, this report also recommends that the project develop a strategy focused on maintaining the motivation and morale of CHW, all of whom function as volunteers. Toward this end, we recommend that the strategy should ensure that all CHWs are
equipped with satchels large enough to carry and protect their community-based drug supplies, with bicycles and basic repair kits for bicycles, and with basic supplies such as gloves, cotton, and raincoats. In addition, it is recommended that, as noted earlier in the findings, the project should support the design and mass-production of basic health guidance postcards (dépliants in Kirundi) that CHWs and their health center-based health promotion technicians (techniciens de promotion de la santé or TPS) can use to promote communities' understanding and support for integrated health services, for timely visits to health centers and for the importance of preventive health care.

2. What changes can be made in program design or implementation to result in more effective and/or efficient execution and improved results?

Training in data for decision-making purposes: With only two years left before the IHPB completes its contract, there is limited opportunity to make changes in the program’s design. However, in addition to recommendations noted in the above paragraph, it is recommended that the project increase capacity in the use of data for decision-making of health service providers, especially those who are health service managers, or titulaires. Currently, health service managers reportedly expend significant effort hand-tabulating and transmitting health service delivery data to district health offices without receiving any feedback on the data or on the data’s implications for ways in which their health centers can improve the quality of services.

3. Recommended actions and/or decisions to be taken by management.

Enhanced government ownership and sustainability: Although the evaluation team is aware that the IHPB has developed an exit plan for sustainability, there is no evidence that district health managers have been engaged in the development of the plan. Moreover, IHPB has indicated in its communications with the evaluation team that it is the project’s intention to introduce the exit plan in its final year of operations. Based on KII discussions with respondents in all four IHPB provinces, it would appear that the project’s attention to implementation of an exit strategy only during its final phase would be ill-advised and unnecessarily delayed.

Accordingly, it is recommended that the project define an action-oriented strategy to implement its exit plan. It is further recommended that this strategy include immediate participatory discussions with central, provincial, and district-level administrative and health authorities focused on reviewing the exit plan and on developing a consensus with the government on the exit plan’s content, focus, approach, and timing. As a minimum requirement, the revised exit plan should emphasize the roles of central programs and health districts for an increased sense of ownership of the IHPB achievements. Finally, once this consensus is reached, it is recommended that the project support the government’s full participation in the execution of the exit plan.

Lobbying for free pregnancy testing: The provision of free pregnancy testing was cited by the evaluation’s respondents as an important means of enhancing health facilities’ ability to reach out to clients at the earliest possible stage in their health care cycles. Toward that end, it is recommended that the project’s senior central technical officers work with allied projects, donor agencies, NGOs, and the government to launch a policy initiative focused on sensitizing senior government officials to the importance of providing health service clients with free pregnancy testing, a policy that would include family planning counseling and, if indicated, the provision of contraceptives.

Documentation: As discussed in the report’s section on findings, the IHPB has developed and produced a significant amount of project reports, assessments, surveys and technical documents.
In entering its fourth year of operations, the project is certain to produce more background material and supporting documentation related to the coming year’s activities. Accordingly, the evaluation team, supported by the evaluation’s respondents, recommends that the project devote sufficient time, during the project’s final quarter of operations, to document the project’s initiatives and its progress toward its defined objectives. As an in-house commentary and summary of the project’s historical development, the recommended documentation, prepared by senior project staff, should include a detailed and objective analysis and subsequent discussion of the project’s objectives, successes, challenges, and constraints, as well as its lessons learned, and guidance on ways in which to build upon progress achieved in introducing the concept of integrated services within its four targeted provinces. Finally, it is recommended that the documentation initiative be enhanced through a series of information-sharing workshops or symposiums during which project staff will engage key stakeholders in in-depth discussions on the long-term ramifications of the project’s progress in promoting integrated health services in Burundi.

RECOMMENDATIONS FOR A FUTURE PROJECT

4. What changes are recommended in a future program’s design or implementation that could result in more effective and/or efficient execution and in improved results?

In response to the scope of work’s call for recommendations on the future program’s design and implementation, the following paragraphs present the respondents’ and the evaluation team’s recommendations on (4.1) program design and implementation and (4.2) project content.

Program design and implementation

- **Management as a Cooperative Agreement:** In awarding the IHPB contract to FHI 360 and its collaborating partner, USAID chose a bilateral contract mechanism as its internal management model. Although the evaluation has concluded that IHPB technical implementation was effectively monitored by USAID as a bilateral contract, it is strongly recommended that the future project be awarded as a Cooperative Agreement. In doing so, USAID will provide the future contractor with the necessary added flexibility in working with USAID to effectively respond and adjust to Burundi’s challenging political and health policy environment.

- **Project direction defined through participatory needs-based assessment:** With the goal of developing an informed partnership with the Government of Burundi, it is recommended that USAID and GOB health sector stakeholders define the future project’s technical direction through a participatory assessment of real needs. In recognizing that there are limitations to USAID’s ability to respond to all identified needs, the evaluation team further recommends that the task of identifying priority needs to which USAID can realistically respond be approached as a negotiation between partners, all of whom share an interest in an improved health care environment for Burundian communities. Given the current project’s emphasis on a limited number of facilities in four of Burundi’s provinces, one of the issues that will require consideration is whether USAID resources will be sufficient to extend the project’s outreach beyond areas currently benefiting from the IHPB’s technical assistance.

- **Participatory design, implementation, and monitoring of the future project:** Aligned with the above recommendation and as noted in this report’s discussion on findings, respondents at all levels of the evaluation expressed concern with the lack of
national/provincial/district-level participation in the design of the project. A similar level of concern was expressed by the evaluation’s respondents with the limited participation of provincial and district-level stakeholders in the project’s implementation. From the standpoint of ownership of and contribution to the IHPB’s objectives, this evident lack of effective partnership represented a significant constraint to the project’s ability to work towards end-of-project sustainability of initiatives introduced by the project. Accordingly, once it is determined that there will be a follow-on project, it is recommended that key stakeholders be fully involved at all stages of the project’s design, in its implementation, and in monitoring the project’s progress toward agreed-upon objectives and indicators. Adherence to this recommendation will enhance prospects for sustainability following the new project’s completion.

**Project content**

- **Integration**: As noted in several instances in this report, the IHPB has made significant initial progress on introducing the concept of integration as an effective mechanism for enhancing client access and utilization of priority health care services. Accordingly, it is recommended that the new project build on the IHPB’s success through the development and execution of a proactive approach to the promotion of comprehensive integration of health service delivery. However, if the future project is to focus on integration, it is further recommended that every effort be expended to truly integrate all technical project technical assistance rather than providing for a project whose emphasis retains the vertical approach currently practiced by the IHPB.

- **Human resources for health**: As noted throughout this report, deficits in human resources for health (HRH)—most especially at the level of health centers—are a significant impediment to expectations of sustainable improvement in basic health indices. Although addressing HRH issues is clearly beyond the technical scope of a health service delivery project, it is recommended that the project’s future design incorporate a collaborative linkage with USAID’s Human Resources for Health (HRH) project, HRH2030.

- **Enhanced focus on community health care**: As discussed in this report’s findings, the evaluation’s respondents reported a significant level of support for IHPB’s promotion of the CHW’s role in promoting positive change in clients’ attitude and behavior toward preventive and curative health care and toward their timely use of health services. Moreover, this evaluation’s service provider respondents have indicated that, of all IHPB initiatives, the introduction of the concept of integration and the enhancement of the capacity of CHWs stand the greatest chance of being sustained following the IHPB’s completion of its contract. Accordingly, it is strongly recommended that enhanced support of CHWs should constitute a principal initiative of the future project.

- **Continue and expand technical focus on most vulnerable groups**: On the basis of the evaluation team’s discussions with key informants, CHWs, and clients themselves, on field observations and on a review of project documentation, it is recommended that the future project continue its emphasis on responding to the health care needs of those clients whose health status is the most vulnerable. Under the IHPB, this group of most vulnerable clients included women at risk during pregnancies and children under five years of age. While the evaluation team supports continued emphasis on this
important at-risk group of clients, it is recommended that the definition of most vulnerable be extended to include children of all age groups, victims of gender-based violence, males as well as females faced with the threat of HIV and sexually-transmitted infections, and youth of both sexes with limited knowledge of the risks—and the choices—associated with sexual activity, with unintended pregnancies, and with timely access to health care.

- **Revise strategies for technical interventions:** As the IHPB has achieved many of its targets—as judged by its success and exceeding Y3 indicator targets—it is reasonable to expect that end-of-project (EOP) targets will be met and even exceeded. However, in looking forward to the future, it is recommended that those responsible for the design of the new project define a health intervention strategy—including accompanying indicators—that more realistically reflect Burundi’s health service delivery constraints.

- **Response to identified basic health infrastructure strengthening:** While beyond the scope of a health services activity and admittedly an area in which the needs far exceed the possibilities for support, the weak state of much of Burundi’s health infrastructure would argue against a future project’s having any assurance of the sustainability of its interventions. Accordingly, it is recommended that the future project’s geographical and institutional coverage be limited to those areas in which there are documented plans for governmental or donor funding for basic health service infrastructure development. To be clear, it is not recommended that the new project include a technical component dedicated to infrastructure development, as few, if any, projects have demonstrated a capacity to address both technical and infrastructure development needs. Rather, it is recommended that the future project’s technical assistance development model be adjusted to provide for a partnership with an entity whose capacities would permit them to identify and address identified basic infrastructure needs in tandem with the future project’s promotion of integrated health care.

5. **What potential new solutions to problems faced by the project could be introduced in a new project?**

**Focus on the development and support of provincial hospitals as centers of excellence:** As discussed in this report’s section on findings, multiple sources, including those from within the IHPB, noted the district-level’s limited engagement in and ownership of the project’s goal of increasing capacity to deliver quality integrated health and support services. From a program management perspective, recommendations proposed above represent a necessary but partial solution to the need for increased governmental ownership of the future project’s goals and objectives. However, from the respondents’ and the evaluation team’s technical perspective, full engagement of the government in the new project’s technical focus requires that health providers themselves have a clearly-defined role in the progressive attainment of desired levels of technical capacity. Accordingly, it is recommended that the new project’s technical and operational focus be built around the establishment and support of a selected number of provincial hospitals as centers of excellence. It is further recommended that, once selected, the provincial center of excellence hospitals should constitute the central focal point from which the new project’s provincially-based technical teams would work with center of excellence counterparts toward a collaborative technical strengthening of health center technical and operational capacity. In essence, this recommendation calls for a “spoke-and-wheel” project technical construct in which the project’s major personnel, technical, and operational inputs are located at provincial rather than at central level.
Support for provincial hospital centers of excellence: As discussed in the preceding paragraph, it is recommended that the future project restructure its technical assistance model to focus on developing selected provincial hospitals as centers of excellence, each of which will represent the central point of a “wheel” within which client health centers—or spoke—will be beneficiaries of technical assistance provided by province-based project technical teams in concert with their center of excellence counterparts. The principal elements of this recommended model are as follows:

- Each technical team will be responsible for developing the capacity of the provincial hospital center of excellence and for facilitating the formation, support, and capacity development of a permanent hospital-based integrated services team. Comprised of the project’s technical assistance team and assigned hospital counterparts, the Integrated Services Team (IST) will be responsible for:
  - Identifying and responding to technical needs associated with transforming the provincial hospital into a center of excellence.
  - Assessing and responding, through a defined action plan, to integrated health capacity-development needs of client health centers within the province.
  - Developing and supporting, within the province, a defined but limited number of Health Center Models of Excellence, each of which will be a focal point for IST-provided continuing education and support for other health centers in its area and for support and enhancement of the quality of services provided by community health workers.
  - Developing, implementing, and monitoring a regional project exit plan that emphasizes promoting the long-term sustainability of initiatives introduced by the IST. From a technical standpoint, the IST’s exit plan, developed in concert with district and provincial health officers, should include the scheduling of technical project-supported milestones, with the documented attainment of each milestone serving as a certification of the province’s agreement to the transfer of responsibility from the project to the province for future technical, managerial, and financial support for a specific initiative.

6. What actions and/or decisions should be taken by management in a future project?

Organizational and technical structuring of the future project’s central office: As discussed in this report’s findings, the IHPB has made a significant contribution to establishing a framework for the integration of health services within health centers and in communities in its four target provinces. However, if the goal of the future project is to build upon and significantly scale up the quality of integrated services and if the recommended decentralized project model is to function as intended, it is recommended, for the purposes of cost-effectiveness and efficiency, that the number of personnel at the project’s central offices be significantly reduced, with the central office personnel focusing on the following initiatives:

- **Project management**: If the decentralized, province-focused future project is to function as recommended, it is proposed that a major function of the central office will be to ensure that the project fulfills contractual obligations associated with project representation, financial management, timely reporting, purchasing of supplies and
equipment, production of technical material, and recruitment of national and international staff and short-term consultants.

- **Technical and managerial supervision, oversight, and support of provincial project technical assistance teams:** While it is recommended that the provincial technical assistance teams be fully qualified and constituted to respond to their technical assistance, managerial, and administrative responsibilities, it is recommended that, overseen by the project’s Chief of Party, a small central-level core group (perhaps one senior technical officer and one management officer per province) be constituted to ensure that each provincial team has full-time access to senior-level technical support/oversight and to all necessary material, logistical, and administrative support. Working together with the provincial teams and with short-term consultants, the central-level senior technical officer would also be responsible for assisting provincial teams in defining the technical parameters of province-directed assessments, surveys, research, and data collection and analysis. In addition, it is proposed that the core group of technical officers would be responsible for working with short-term consultations in the preparation of technical documents associated with supporting provincial ISTs.

- **Policy and communications support:** In addition, it is recommended that the central-level staff include an experienced technical officer responsible for working with the Ministry of Health to promote the adoption and institutionalization of policy associated with the ISTs provincial-level initiatives.

- **Pre-service training:** It is recommended that future activities include a training initiative focused on developing and introducing an integration curriculum into Burundi’s medical and training schools.

- **Coordination and monitoring of provincial-level exit plans:** As noted above, it is recommended that the ISTs develop an exit plan focused on promoting prospects for the long-term sustainability of IST-introduced initiatives. As this report’s final recommendation, it is proposed that the central office core team, led by the Chief of Party, proactively coordinate the monitoring of all provincial exit plans.
ANNEX A. SCOPE OF WORK

Assignment #: 254 [assigned by GH Pro]

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

EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: 5-26-2016
Last update: 8-10-2016

I. TITLE: USAID/Burundi – Integrated Health Project Burundi Performance Evaluation

II. Requester / Client
☒ USAID Country or Regional Mission
Mission/Division: Burundi /

III. Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)
☒ 3.1.1 HIV
☐ 3.1.2 TB
☐ 3.1.3 Malaria
☒ 3.1.4 PIOET
☐ 3.1.5 Other public health threats
☒ 3.1.6 MCH
☐ 3.1.7 FP/RH
☐ 3.1.8 WSSH
☐ 3.1.9 Nutrition
☐ 3.2.0 Other (specify):

IV. Cost Estimate: (Note: GH Pro will provide a cost estimate based on this SOW)

V. Performance Period
Expected Start Date (on or about): August 18, 2016
Anticipated End Date (on or about): December 30, 2016

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

VII. Type of Analytic Activity (Check the box to indicate the type of analytic activity)
EVALUATION:
Performance Evaluation (Check timing of data collection)
☐ Midterm ☐ Endline ☐ 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.

☐ Impact Evaluation (Check timing(s) of data collection)
☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):
Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES
☐ Assessment
Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

☐ Costing and/or Economic Analysis
Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

☐ Other Analytic Activity (Specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)
Note: If PEPFAR funded, check the box for type of evaluation

☐ Process Evaluation (Check timing of data collection)
☐ Midterm ☐ Endline ☐ Other (specify):
Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affects implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

☐ Outcome Evaluation
Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

☐ Impact Evaluation (Check timing(s) of data collection)
☐ Baseline ☐ Midterm ☐ Endline ☐ Other (specify):
Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

☐ Economic Evaluation (PEPFAR)
Economic Evaluation identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

VIII. BACKGROUND
If an evaluation, Project/Program being evaluated:

<table>
<thead>
<tr>
<th>Project Title:</th>
<th>Integrated Health Project Burundi (IHPB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contract Number:</td>
<td>AID-623-C-14-00001</td>
</tr>
<tr>
<td>Contract Dates:</td>
<td>10/01/2013-09/30/2018</td>
</tr>
<tr>
<td>Project Funding:</td>
<td>$40,735,141</td>
</tr>
<tr>
<td>Implementing Organization(s):</td>
<td>Family Health International (FHI 360)</td>
</tr>
<tr>
<td>Project COR:</td>
<td>Dr. Lievin Nsabiyumva</td>
</tr>
</tbody>
</table>

Background of project/program/intervention:
The IHPB works with the Government of Burundi (GOB), civil society organizations (CSOs), communities, and other development partners to integrate and improve health behaviors, services and systems across families, communities, facilities, and districts. The project builds on USAID’s legacy of support to address HIV/AIDS, malaria, family planning and reproductive health, and maternal and child health needs in Burundi. At the end of the project’s five years, the Burundian government, CSOs, and supported communities will have demonstrably increased capacity to deliver quality integrated health and support services and communications and behavioral interventions. In addition, the implementing partner shall have contributed to the increased sustainability of project investments in a measurable manner.

Project Summary
The Integrated Health Project in Burundi has three integrated objectives:
1. Increased positive behaviors at the individual and household levels

   CLIN 1 includes IHPB’s activities in social and behavior change communication (sub-CLIN 1.1), supply chain management (sub-CLIN 1.2), and gender integration and gender based violence service strengthening (sub-CLIN 1.3).
   - Sub-CLIN 1.1: Improved key behavioral pre-determinants at the individual, household, and community levels
   - Sub-CLIN 1.2: Increased accessibility and availability of health products to individuals and households
   - Sub-CLIN 1.3: Strengthened support for positive gender norms and behaviors and increased access to GBV services

2. Increased use of quality integrated health and support services

   CLIN 2 serves as the locus of IHPB’s work to support strengthening and expansion of community health workers and community health committees (COSA) (Sub-CLIN 2.1); continuation of essential services and prioritization, testing, and roll-out of integrations and improvements to services (Sub-CLIN 2.2); and strengthening the capacity of the District Health Bureaus (BDS) human resource management system and health facility managers (Sub-CLIN 2.3).
   - Sub-CLIN 2.1: Increased access to health and support services within communities
   - Sub-CLIN 2.2: Increased percent of facilities that provide quality integrated health and support services
Sub-CLIN 2.3: Increased capacity of providers and managers to provide quality integrated health services

3. **Strengthened health systems and capacity**

CLIN 3 activities will strengthen the capacity of local district partners to plan, oversee, manage and deliver essential and integrated services in an effective, efficient and responsive decentralized health system. Under Sub-CLIN 3.1, IHPB will help the GOB put in place the policies, district management capacities, infrastructure and equipment needed to support essential and integrated health services. Under Sub-CLIN 3.2, the project will help districts put data quality systems in place, reform data flows and continuously improve how data is analyzed and used in routine monthly and quarterly meetings. Under Sub-CLIN 3.3, the project will provide intensive technical assistance and grants to four CSOs to strengthen their critical roles in district health systems, including service delivery, governance and community mobilization.

   Sub-CLIN 3.1: Strengthened decentralized health care and systems in targeted geographic areas
   Sub-CLIN 3.2: Strengthened monitoring and evaluation (M&E) and data management systems at facility and community levels
   Sub-CLIN 3.3: Increased civil society capacity to support positive behaviors and quality integrated services

**PRIORITY HEALTH DOMAIN STRATEGIES**

While IHPB is pursuing integrated solutions to address individual, household, and community health needs, the project also works to ensure that the interventions it promotes align with latest scientific evidence and USG standards and norms for effective programming in specific technical domains. Following are strategies for the project’s activities in priority health domains: malaria; child health; maternal health; RH/FP; and HIV/AIDS. The Integrated Package of Health Services Provided by the Project is listed in Annex 4.

**Malaria Strategy**
- Community Case Management (CCM) of malaria at the community level
- Improve intermittent preventative treatment during pregnancy (IPTp) implementation in health facilities
- Support behavior change communication efforts for malaria prevention and treatment
- Strengthen district and facility level supply chain logistics and pharmaceutical management
- Improve case management in health facility

**Child Health Strategy**
- Improving Immunization services
- Improving clinical integrated management of childhood illnesses (IMCI) services
- Improving nutrition services

**Maternal and Newborn Health Strategy**
- Enable and ensure supportive supervision
- Elaborate and validate tools for and support continuation of maternal death audits
- Produce and disseminate registers for maternal health services
- Train providers on basic emergency obstetric and newborn care
- Train providers on essential obstetric and newborn care
- Coordination meeting on antenatal care and skilled birth attendance

**Reproductive Health and Family Planning Strategy**
- Conduct monthly follow-up on family planning activities
- Train health promotion technicians on community-based distribution of contraceptives
- Train the project staff and partners on U.S. compliance

**HIV/AIDS Strategy**
- Provide HIV counseling and testing
- Offer anti-retro viral prophylaxis to HIV-positive pregnant women to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery
- Perform virologic HIV test to infants within 12 months of birth
- Offer post-GBV care to survivors
- Continue support to OVCs
- Enroll new HIV-positive adults and children in clinical care during the reporting period.

**CSO Capacity Building**
The IHPB is building the capacity of four CSOs, Association Nationale de Soutien aux Seropositifs et Maladies du SIDA (ANSS), Association Burundais Pour Le Bien Etre Familial (ABUBEF), Society for Women Against AIDS (SWAA) and Reseau Burundais des Personnes Vivant avec le VIH/SIDA (RBP+) to become direct recipients of USAID funds.

**Geographic Areas of the Project**
In its first two years, IHPB worked in four provinces — Karusi, Kayanza, Kirundo and Muyinga — with potential expansion to additional provinces in project years three through five. The project currently works in the following twelve health districts: Buhiga, Nyabikere, Muyinga, Giteranyi, Gashoho, Musema, Gahombo, Kayanza, Kirindo, Busoni, Mukenke, and Vumbi.

**Substantive Changes and Modifications**
In February 2015, FHI 360 proposed a substantive change to the project’s mandatory results and performance indicators. The contract was modified in August 2015 to include these revisions.

Also in FY 2015, USAID/Burundi determined that FHI 360 was not meeting required results for the PEPFAR Orphans and Vulnerable Children (OVC) earmark. As such, OVC funding was reduced during FY 2016 with the plan for OVC activities to be transitioned out of the IHPB.

**Summary of the Project Analyses**
The IHPB has completed the following Formative Analysis and Baseline Assessments that will be available to the evaluation team:
- Services Availability and Readiness Assessment (SARA) of 173 health facilities (164 HCs and 9 hospitals).
- Community Services Mapping
- Qualitative Behavioral survey and Gender Assessment
- Household Survey (HH)
- Health Services Qualitative Assessment of a sample of 45 health facilities (36 HCs and 9 hospitals).
- Health District Bureau Capacity Assessment: assessed district health teams capacity and issues to perform 11 key management functions in 12 health districts.
Strategic or Results Framework for the project/program/intervention (paste framework below)

If project/program does not have a Strategic/Results Framework, describe the theory of change of the project/program/intervention.

**IHPB Results Framework**

<table>
<thead>
<tr>
<th>Result 1</th>
<th>Result 2</th>
<th>Result 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased positive behaviors at the individual and household levels</td>
<td>Increased quality and use of integrated health and support services</td>
<td>Strengthened health systems and capacity</td>
</tr>
<tr>
<td>Improved behavioral determinants and gender norms</td>
<td><strong>Strengthened community systems and services</strong></td>
<td><strong>Integrated and improved facility services</strong></td>
</tr>
<tr>
<td>SBCC interventions</td>
<td><strong>Strengthen CSOs</strong></td>
<td><strong>Maintain and improve essential services</strong></td>
</tr>
<tr>
<td>SBCC assessment and strategy</td>
<td><strong>Strengthen CHWs and COSAs</strong></td>
<td>Test and scale-up effective integrations</td>
</tr>
<tr>
<td>Grants to CSOs</td>
<td><strong>Community service assessment and strategy</strong></td>
<td><strong>Strengthen capacity of BDS</strong></td>
</tr>
<tr>
<td>CSO capacity assessment and action plan</td>
<td><strong>Basic training, infrastructure, equipment, grants</strong></td>
<td>Health systems assessment and strategies</td>
</tr>
<tr>
<td><strong>Integration and analysis and strategy</strong></td>
<td><strong>Fund PBF</strong></td>
<td></td>
</tr>
</tbody>
</table>
What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

**Target Group:** General population in the geographic region (around 1,000,000 people)

**Active Geographic Regions:** Buhiga, Nyabikere, Muyinga, Giteranyi, Gashoho, Musema, Gahombo, Kayanza, Kirindo, Busoni, Mukenke, and Vumbi.

### 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.

The purpose of this performance evaluation is to assess progress that the Integrated Health Project Burundi (IHPB) has made to date in achieving its objectives and document the effectiveness of the project’s approaches and responsiveness to integrating and improving health behaviors, services and systems. The evaluation will help USAID/Burundi identify how well the implementer has achieved expected project results as well as examine key technical and management systems strengths, weaknesses, opportunities, and threats in the implementation of the IHPB.

**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 primary audience for this evaluation is the USAID/Burundi Health Office. Other users include the USAID Washington Global Health Bureau, USAID Presidential Malaria Initiative, and the Office of the Global AIDS Coordinator who have all contributed funds to implement the project. Other key audiences include the Burundi Country Representative, USAID/Burundi Program Office, Embassy Bujumbura Front Office, in the context of their collaboration to implement the IHPB, and USAID/Rwanda.

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

The findings will be used by USAID/Burundi and the implementer to develop and support activities to strengthen the project’s implementation to improve performance over the remaining project life, help USAID determine what steps to take to sustain the project achievements, and help USAID design future health activities.

**D. Evaluation Questions & Matrix:**

a) Questions should be: a) aligned with the evaluation/analytic 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/analytic questions. **USAID policy suggests 3 to 5 evaluation questions.**

b) List the recommended methods that will be used to collect data to be used to answer each question.

c) State the application or use of the data elements towards answering the evaluation questions; for example, i) ratings of quality of services, ii) magnitude of a problem, iii) number of events/occurrences, iv) gender differentiation, v) etc.

The Performance Evaluation will respond to the following questions and provide recommendations, where appropriate. These questions have been formulated based on the

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21 Every health district covers around 150,000 people
The evaluation will assess project implementation from December 2013 to June 2016. The evaluation will make conclusions based on findings, identify challenges and opportunities, and formulate recommendations for improvements across existing program activities.

The key evaluation questions are listed below, to be refined during the planning and startup process. The primary issue to be assessed is the integration approach. The Evaluation Team will complete this matrix and submit to USAID as part of their Evaluation Protocol, due at same time as the draft evaluation work plan and protocol.

Evaluation Matrix will be completed by Evaluation Team during virtual team planning work, prior to arrival in country.

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Anticipated Data Sources</th>
<th>Proposed Data Collection Methods</th>
<th>Data Analysis Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To what extent has the IHPB achieved its intended objective to increase quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. To what extent has the IHPB achieved its intended objectives to strengthen health capacity and systems?</td>
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<td></td>
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<tr>
<td>3. How well is the integration of health services approach working in the covered area?</td>
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<tr>
<td>4. What lessons learned can inform project management for the remainder of the project life and future potential follow-on designs?</td>
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</tr>
</tbody>
</table>

Other Questions [OPTIONAL]
(Note: Use this space only if necessary. Too many questions lead to an ineffective evaluation or analysis.)

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

General Comments related to Methods:
The evaluation team will use available quantitative data from the IHPB baseline studies conducting in Year 1 of the project and collect qualitative data to conduct the performance evaluation. The evaluation team should provide a performance evaluation design, including an evaluation methodology, identifying proposed questions for key informant interviews and focus groups, selection methods, data collection tools and the data analysis plan with a description of the specific data collection and analysis methods, to be linked to one or more of the key evaluation questions above, and a timeline for each task. The Evaluation Team should include a completed Evaluation Planning Matrix in the submission of the draft evaluation protocol. Draft data collection tools shall be shared with USAID/Burundi two weeks prior to departure to the field.

Where limitations of the proposed evaluation design and methodology are found (e.g., data quality issues or lack of baseline data on some indicators), the offeror is requested to identify these limitations and any mitigating actions (proposed to be) taken in the proposal and final evaluation report.

The sampling criteria and initial sample of sites will be selected prior to arrival in Burundi and finalized during the Team Planning Meeting (TPM). It is anticipated the Team will visit all 12 districts where IHPB works, using the sampling criteria to select health facilities within these 12 districts.

Document and Data Review (list of documents and data recommended for review)
This desk review will be used to provide background information on the project/program, and will also provide data for analysis for this evaluation. Documents and data to be reviewed include:

<table>
<thead>
<tr>
<th>Document and Data</th>
<th>Year</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>PEPFAR Country Operational Plan</td>
<td>2015 2016</td>
<td>USAID</td>
</tr>
<tr>
<td>Malaria Operational Plan</td>
<td>2015 2016</td>
<td>USAID</td>
</tr>
<tr>
<td>GOB National Health and Development Plan</td>
<td></td>
<td>GOB</td>
</tr>
<tr>
<td>Burundi National Strategic Plans for: HIV/AIDS, Malaria, TB, and RH</td>
<td></td>
<td>GOB</td>
</tr>
<tr>
<td>Community Services Mapping</td>
<td>2014</td>
<td>IHPB</td>
</tr>
<tr>
<td>Annual Work Plans for Years 1 – 3</td>
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<td>IHPB</td>
</tr>
<tr>
<td>Annual Reports for Years 1-2, with indicator data</td>
<td></td>
<td>IHPB</td>
</tr>
<tr>
<td>Quarterly Reports for Years 1-3</td>
<td></td>
<td>IHPB</td>
</tr>
<tr>
<td>IHPB Gender Assessment Report</td>
<td></td>
<td>IHPB</td>
</tr>
<tr>
<td>Service Availability and Readiness Assessment Report (SARA)</td>
<td>2015</td>
<td>IHPB</td>
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<tr>
<td>IHPB M&amp;E Plan</td>
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<tr>
<td>IHPB PMEP with Performance Indicator Reference Sheets</td>
<td>2016</td>
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<tr>
<td>Revision of Mandatory Indicators</td>
<td>2015</td>
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<tr>
<td>Indicators from the 2015 Burundi Performance Plan and Report (PPR)</td>
<td>2015</td>
<td>USAID</td>
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<tr>
<td>Innovation studies</td>
<td>2014</td>
<td>IHPB</td>
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<tr>
<td>Statement of Work from the USAID contract with FHI 360</td>
<td></td>
<td>USAID</td>
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<tr>
<td>Household Survey</td>
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<td>IHPB</td>
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<td>Health Services Qualitative Assessment</td>
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<tr>
<td>Health District Bureau Capacity Assessment</td>
<td></td>
<td>IHPB</td>
</tr>
</tbody>
</table>
USAID/BURUNDI INTEGRATED HEALTH PROJECT BURUNDI MID-TERM PERFORMANCE EVALUATION / 52

Annual Performance Plan and Report (PPR) (attached in Annex 1 & 2)  USAID


Existing project related data and reports, including SARA, household survey, behavioral survey, capacity assessments, etc.,

Capacity assessment data and reports from all 12 districts

The Evaluation Team should submit background documents reviewed that were not provided by USAID to USAID/Burundi for their records.

☐ Secondary analysis of existing data (This is a re-analysis of existing data, beyond a review of data reports. List the data source and recommended analyses)

<table>
<thead>
<tr>
<th>Data Source (existing dataset)</th>
<th>Description of data</th>
<th>Recommended analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Key informant interviews with IHPB project staff, staff from the four CSOs that received capacity building, national and local government officials, and other program stakeholders. Key informant interviewees should include both men and women and activities from Karusi, Kayanza, Kirundo and Muyinga provinces and all twelve health districts. USAID/Burundi will provide a list of contacts that the evaluators should consider for key informant interviews. The Evaluation Team will provide USAID with a proposed list of questions and a selection methodology for how interviewees will be selected in the evaluation plan. A comprehensive list of the roles of all key informants will be included as an annex to the final evaluation report. The sample selected should be as robust and representative as possible to reduce bias to ensure objectivity of evaluation findings.

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

Focus group discussions (FGD) with program beneficiaries and CHWs. Focus group participants should be representative of both men and women. Men and women will participate in separate FGDs to adjust for the potential power differential between men and women, and to assure women’s voice is heard equally to men. The Evaluation Team will provide a proposed list of questions and selection methodology for how participants in focus group discussions will be selected in the evaluation plan. A comprehensive list of the nature of all focus groups (e.g., “Focus Group Discussion with XX Female Beneficiaries in Province X”) will be included as an annex to the final evaluation report.

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

Optional: Key informants can be grouped and interviewed together, as long as the respondents feel free to express their opinions openly.

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

☐ Survey (describe content of the survey and target responders, and purpose of inquiry)
☐ **Facility or Service Assessment/Survey** (list type of facility or service of interest, and purpose of inquiry)

☐ **Observations** (list types of sites or activities to be observed, and purpose of inquiry)

Using a semi-structure observation data collection form, the Team will visit select health facilities to observe wait time, patient flow, approaches to integrated services (e.g., during infant/child health visits are women counseled and offered FP). Specifics related to priorities for observations will be determined and site selection will be finalized during the virtual TPM, prior to arrival in country.

☐ **Cost Analysis** (list costing factors of interest, and type of costing assessment, if known)

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

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

☐ **Verbal Autopsy** (list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population)

☐ **Rapid Appraisal Methods** (ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)

☐ **Other** (list and describe other methods recommended for this evaluation/analytic, and purpose of inquiry)

If **impact evaluation** –

Is technical assistance needed to develop full protocol and/or IRB submission?

☐ Yes ☐ No

List or describe case and counterfactual”

<table>
<thead>
<tr>
<th>Case</th>
<th>Counterfactual</th>
</tr>
</thead>
</table>

**X. HUMAN SUBJECT PROTECTION**

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

An Informed Consent statement, in Kirundi and French, included in all data collection
interactions must contain:
- Introduction of facilitator/note-taker
- Purpose of the evaluation
- Purpose of interview/discussion/survey
- Statement that all information provided is confidential and information provided will not
  be connected to the individual
- Right to refuse to answer questions or participate in interview/discussion/survey
- Request consent prior to initiating data collection (i.e., interview/discussion/survey)

XI. 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 interviews data, or a descriptive analysis of quantitative survey
data.

All analyses will be geared to answer the evaluation questions. Additionally, the evaluation will
review both qualitative and quantitative data related to the project/program’s achievements
against its objectives and/or targets. It is anticipated that this evaluation will collect more
qualitative data, but will also include some quantitative data.

Quantitative data will be analyzed primarily using descriptive statistics. Data will be disaggregated
by demographic characteristics, such as sex, age, and location, whenever feasible. Other
statistical tests will be run as appropriate.

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

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

The Evaluation Report will describe analytic methods and statistical tests employed in this
evaluation within the Methods section of the Evaluation Report, with further details (as needed)
within an annex.

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

Background reading – Several documents are available for review for this analytic activity.
These include IHPB proposal, annual work plans, M&E plans, monthly and quarterly progress
Draft Evaluation Workplan and Protocol will be submitted to USAID/Burundi prior to the Evaluation Team convening in country, with a final workplan and protocol due at the close of the TPM that includes:

- Evaluation matrix, including evaluation methods
- Criteria for purposive sampling for health facility site selection
- Evaluation questions
- Data collection plan
- Evaluation workplan for USAID’s approval
- Data collection methods, with instruments, tools and guidelines, including consent statements
- Assignment timeline
- Timeline for field work and deliverables

These documents will be the foundation of discussions with USAID during the in country TPM.

Team Planning Meeting (TPM) – The TPM be initiated remotely before the Team convenes in Burundi, and then will continued in Burundi, before the data collection begins. During the TPM the team will finalize:

- Evaluation questions
- Team members’ roles and responsibilities
- Team dynamics and approach to work, including individual working styles and procedures for resolving differences of opinion
- Assignment timeline
- Data collection methods, instruments, tools and guidelines with consent statements
- Logistical and administrative procedures for the assignment
- Data collection plan
- Evaluation workplan for USAID’s approval
- Preliminary draft outline of the team’s report
- 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 with USAID prior to the Team convening in Burundi. This is a call/meeting among the USAID, GH Pro and the Team Lead to initiate the evaluation activity and review expectations. USAID will review the purpose, expectations, and agenda of the assignment. GH Pro will introduce the Team Lead, and review the initial schedule and review other management issues.
- Evaluation Launch with IHPB prior to the Team convening in Burundi. This is a call to introduce the Evaluation Team Lead to the IHPB Chief of Party to discuss the upcoming evaluation, expectations, and communication needs.
- In-brief with USAID, as part of the TPM. At the beginning of the TPM, the Evaluation Team will meet with USAID to discuss expectations, review evaluation questions, and the draft workplan. The Team will also raise questions that they may have about the project and SOW resulting from their background document review. The time and place for this in-brief will be determined between the Team Lead and USAID prior to the TPM.
• **Workplan and Protocol briefing.** At the end of the TPM, the Evaluation Team will meet with USAID to present an outline of the methods/protocols, timeline and data collection tools. This will be a revision of the Draft Workplan previously submitted, prior to arrival in Burundi. Also, the format and content of the Evaluation report(s) will be discussed.

• **In-brief with project** to review the evaluation plans and timeline, and for the project to give an overview of the project to the Evaluation Team.

• The Team Lead (TL) will brief the USAID weekly to discuss progress on the evaluation. As preliminary findings arise, the TL will share these during the routine briefing, and in an email.

• A **final debrief** between the Evaluation Team and USAID will be held at the end of the evaluation to present preliminary findings to USAID. During this meeting, a summary of the data will be presented, along with high level findings and draft recommendations. For the debrief, the Evaluation Team will prepare a **PowerPoint Presentation** of the key findings, issues, and recommendations. The Team will submit the PowerPoint slides to USAID 24 hours before the presentation. The evaluation team shall incorporate comments received from USAID during the debrief in the evaluation report. (Note: preliminary findings are not final and as more data sources are developed and analyzed these finding may change.)

• **IHPB and Stakeholders’ debrief/workshop** will be held with the project staff and other stakeholders identified by USAID. This will occur following the final debrief with the Mission, and will not include any information that may be procurement sensitive or determined to be not suitable by USAID. This workshop will be confirmed prior to arrival in country.

**Fieldwork, Site Visits and Data Collection** – The evaluation team will conduct site visits to for data collection. Selection of sites to be visited will be finalized during TPM in consultation with USAID. The evaluation team will outline and schedule key meetings and site visits prior to departing to the field.

**Evaluation/Analytic Report** – The Evaluation/Analytic Team under the leadership of the Team Lead will develop a report with findings and recommendations (see Analytic Report below). Report writing and submission will include the following steps:

1. Team Lead will submit **draft evaluation report** to GH Pro for review and formatting
2. GH Pro will submit the draft report to USAID
3. USAID will review the draft report in a timely manner, and send their comments and edits back to GH Pro
4. GH Pro will share USAID’s comments and edits with the Team Lead, who will then do final edits, as needed, and resubmit to GH Pro
5. GH Pro will review and reformat the **final Evaluation/Analytic Report**, as needed, and resubmit to USAID for approval.
6. Once Evaluation Report is approved, GH Pro will re-format it for 508 compliance and post it to the DEC.

The Evaluation Report excludes any procurement-sensitive and other sensitive but unclassified (SBU) information. This information will be submitted in a memo to USAID separate from the Evaluation Report.

**Data Submission** – All quantitative data will be submitted to GH Pro in a machine-readable format (CSV or XML). The datasets created as part of this evaluation must be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. It is essential that the datasets are stripped of all identifying information, as the data
will be public once posted on USAID Development Data Library (DDL).

GH PRO will submit a synthesis of all data used (project performance indicators, health information system statistics, demographic, and other survey data) in an Excel workbook or similar format to USAID/Burundi.

Where feasible, qualitative data that do not contain identifying information should also be submitted to GH Pro.

**XIII. 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.

<table>
<thead>
<tr>
<th>Deliverable / Product</th>
<th>Timelines &amp; Deadlines (estimated)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒ Launch briefing with USAID</td>
<td>August 18, 2016</td>
</tr>
<tr>
<td>☒ Launch briefing with IHPB</td>
<td>August 22, 2016</td>
</tr>
<tr>
<td>☒ Draft Workplan and data collection tools</td>
<td>September 1, 2016</td>
</tr>
<tr>
<td>☒ In-brief with USAID</td>
<td>September 6, 2016</td>
</tr>
<tr>
<td>☒ Workplan and Eval Protocol briefing with USAID</td>
<td>September 8, 2016</td>
</tr>
<tr>
<td>☒ Workplan with timeline</td>
<td>September 9, 2016</td>
</tr>
<tr>
<td>☒ Evaluation protocol with data collection tools</td>
<td>September 9, 2016</td>
</tr>
<tr>
<td>☒ In-brief with IHPB</td>
<td>September 9, 2016</td>
</tr>
<tr>
<td>☒ Routine briefings</td>
<td>Weekly</td>
</tr>
<tr>
<td>☒ Out-brief with USAID with Power Point presentation</td>
<td>October 5, 2016</td>
</tr>
<tr>
<td>☒ Findings review workshop with stakeholders with Power Point presentation</td>
<td>October 6, 2016</td>
</tr>
<tr>
<td>☒ Draft report</td>
<td>GH Pro: October 27, 2016 GH Pro submits to USAID: November 4, 2016</td>
</tr>
<tr>
<td>☒ Final report</td>
<td>GH Pro: December 1, 2016 GH Pro submits to USAID: December 6, 2016</td>
</tr>
<tr>
<td>☒ Raw data (cleaned datasets in CSV or XML with data dictionary or code sheet)</td>
<td>GH Pro: November 17, 2016</td>
</tr>
<tr>
<td>☒ Synthesis of the data used (project performance indicators, health information system statistics, demographic and other survey data) in an Excel workbook or similar format</td>
<td>GH Pro Submits to USAID: November 21</td>
</tr>
<tr>
<td>☒ Report Posted to the DEC</td>
<td>December 30, 2016</td>
</tr>
<tr>
<td>☐ Other (specify):</td>
<td></td>
</tr>
</tbody>
</table>

Estimated USAID review time
Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 15 Business days

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

Evaluation/Analytic team: When planning this analytic activity, consider:
• Key staff should have methodological and/or technical expertise, regional or country experience, French and/or Kirundi language skills, team lead experience and management skills, etc.
• Team leaders for evaluations/analytics 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.
• 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.

**Team Qualifications:** Please list technical areas of expertise required for these activities
- List desired qualifications for the team as a whole
- List the key staff needed for this analytic activity and their roles.
- Sample position descriptions are posted on USAID/GH Pro webpage
- Edit as needed GH Pro provided position descriptions

**Overall Team requirements:**
GH Pro will obtain a signed statement from each consultant attesting to a lack of conflict of interest or describe any existing conflict of interest. The evaluation team shall demonstrate familiarity with USAID’s Evaluation Policy and guidance included in the USAID Automated Directive System (ADS) in Chapter 200.

**Team Lead:** This person will be selected from among the key staff, and will meet the requirements of both this and the other position. The Team Leader must be someone external to USAID. S/He should have significant experience conducting project evaluations/analytics.

**Roles & Responsibilities:** The team leader will be responsible for (1) providing team leadership; (2) managing the team’s activities, (3) ensuring that all deliverables are met in a timely manner, (4) serving as a liaison between the USAID and the evaluation/analytic team, and (5) leading briefings and presentations. His/her main role will be to oversee and coordinate all evaluation tasks related to this evaluation, guide other team members and make sure that all deliverables are of high quality and delivered on time. The Team Leader will be ultimately responsible for ensuring the production and completion of a quality report, in conformance with this statement of work and USAID’s evaluation standards. He/she should have a strong background in public health and research methods.

**Qualifications:**
- Master’s degree or higher from a recognized university in Public Health, Monitoring and Evaluation or other related Social Sciences.
- Minimum of 10 years of experience in public health, which included experience in implementation of health activities in developing countries
- At least 8 years of experience in leading evaluations, particularly related to public health or health systems strengthening
- Demonstrated experience leading health sector project/program evaluations, assessments and/or research, utilizing both quantitative and qualitative methods
• Demonstrable ability to lead an evaluation team with a range of backgrounds and expertise
• Experience in conducting evaluations in sub-Saharan Africa (required); having conducted such work in Burundi would be an advantage
• Proven ability to lead teams and work well/interact with USAID, including prior experience as an evaluation team leader for a USAID evaluation
• Excellent skills in planning, facilitation, and consensus building
• Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
• Strong sense of cultural sensitivity
• Excellent skills in project management
• Excellent organizational skills and ability to keep to a timeline
• Good writing skills, with extensive report writing experience
• Familiarity with USAID and PEPFAR
• Familiarity with USAID policies and practices
  • Evaluation policies (USAID)
  • Results frameworks
  • Performance monitoring plans
• Fluency in English and French is required

Key Staff 1 Title: Evaluation Specialist
Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance on evaluation issues, including methods, development of data collection instruments, protocols for data collection, data management and data analysis. S/He will oversee the training of all engaged in data collection, insuring highest level of reliability and validity of data being collected. S/He is the lead analyst, responsible for all data analysis, and will coordinate the analysis of all data, assuring all quantitative and qualitative data analyses are done to meet the needs for this evaluation. S/He will participate in all aspects of the evaluation, from planning, data collection, data analysis to report writing.
Qualifications:
• At least 5 years of experience in USAID M&E procedures and implementation
• At least 3 years managing M&E, including evaluations
• Experience in design and implementation of evaluations
• Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
• Experience implementing and coordinating other to implements surveys, key informant interviews, focus groups, observations and other evaluation methods that assure reliability and validity of the data.
• Experience in data management
• Able to analyze quantitative, which will be primarily descriptive statistics
• Able to analyze qualitative data
• Experience using analytic software
• Demonstrated experience using qualitative evaluation methodologies, and triangulating with quantitative data
• Able to review, interpret and reanalyze as needed existing data pertinent to the evaluation
• Strong data interpretation and presentation skills
• An advanced degree in public health, evaluation or research or related field
• Proficiency in English and French is required
• Good writing skills, including extensive report writing experience
• Familiarity with USAID health programs/projects, primary health care or health systems strengthening preferred
• Familiarity with USAID M&E policies and practices
  – Evaluation policies
  – Results frameworks
  – Performance monitoring plans

Key Staff 2 Title: Technical Specialist for Integrated Health & Support Service
Roles & Responsibilities: Serve as a member of the evaluation team, providing expertise in integrated health and support services, dealing with HIV, malaria, FP and MCH. S/He will participate in planning and briefing meetings, data collection, data analysis, development of evaluation presentations, and writing of the Evaluation Report.
Qualifications:
• At least 5 years’ experience with health projects in sub-Saharan Africa; USAID project implementation experience preferred
• Expertise in supply and demand for health and support services at the community and clinical level
• Familiar with many of the following PEPFAR guidelines and policies, is desirable:
  – PEPFAR Next Generation Indicators Reference Guidance
  – PEPFAR Monitoring, Evaluation, and Reporting Indicator Reference Guide
  – Capacity Building and Strengthening Framework
  – Gender Strategy
• Familiarity with capacity strengthening, and knowledgeable in capacity building assessment (e.g., OCATs) and evaluation methodologies, is desirable
• Excellent interpersonal skills, including experience successfully interacting with host government officials, civil society partners, and other stakeholders
• Proficiency in English and French is required
• Good writing skills, specifically technical and evaluation report writing experience
• Experience in conducting USAID evaluations of health programs/activities

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

<table>
<thead>
<tr>
<th>Local Evaluators (2 consultants)</th>
<th>Local Evaluation Logistics /Program Assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>To assist the Evaluation Team with data collection, analysis and data interpretation. They will provide local context and advice to the evaluation team. The consultants will have basic familiarity with health topics, as well as experience conducting surveys interviews and focus group discussion, both facilitating and note taking. Furthermore, they will assist in translation of data collection tools and transcripts, as needed. They will also assist the Team and the Logistics Coordinator, as needed. They will report to the Team Lead.</td>
<td>will support the Evaluation Team with all logistics and administration to allow them to carry out this evaluation. S/He will have knowledge</td>
</tr>
<tr>
<td>Bachelor’s degree from a recognized university in Public Health, Organizational Development, Monitoring and Evaluation or other related Social Sciences.</td>
<td></td>
</tr>
<tr>
<td>Past experience participating in independent external evaluations of development projects is highly desirable</td>
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<tr>
<td>3-5 years of experience in project/program evaluations</td>
<td></td>
</tr>
<tr>
<td>Excellent computer, data analysis and reporting skills</td>
<td></td>
</tr>
<tr>
<td>Fluency in French and Kirundi is required.</td>
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</tbody>
</table>

USAID/BURUNDI INTEGRATED HEALTH PROJECT BURUNDI MID-TERM PERFORMANCE EVALUATION / 60
of key actors in the health sector and their locations including MOH, donors and other stakeholders. To support the Team, s/he will be able to efficiently liaise with hotel staff, arrange in-country transportation (ground and air), arrange meeting and workspace as needed, and insure business center support, e.g. copying, internet, and printing. S/he will work under the guidance of the Team Leader to make preparations, arrange meetings and appointments. S/he will conduct programmatic administrative and support tasks as assigned and ensure the processes moves forward smoothly. When feasible, s/he may be asked to assist the team in data collection and other evaluation tasks. Additionally, s/he may be asked to assist in translation of data collection tools and transcripts, if needed. He/she should also fulfill the following conditions:

- Bachelor’s from a recognized university
- Experience in conducting operational research studies and both quantitative and qualitative evaluation methodologies
- Demonstrated knowledge in use of different computer-based data analysis tools/programs
- Experience in evaluation management and logistics coordination
- Past experience in participating in independent external evaluations of development projects highly desirable
- Fluency in Kirundi and French is required

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 – If yes, specify who:
☒ Significant Involvement anticipated – If yes, specify who: USAID staff may participate in the evaluation in a limited capacity as observers or to support the evaluation team.
☐ No

Staffing Level of Effort (LOE) Matrix (Optional):
This optional 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.

a) For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.

b) Immediately below each staff title enter the anticipated number of people for each titled position.

c) Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.

d) Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.

e) At the bottom of the table total the LOE days for each consultant title in the ‘Sub-Total’ cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

<table>
<thead>
<tr>
<th>Level of Effort in <strong>days</strong> for each Evaluation/Analytic Team member</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity / Deliverable</strong></td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Number of persons →</td>
</tr>
<tr>
<td>1 Launch Briefing</td>
</tr>
<tr>
<td>Activity / Deliverable</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>2 Desk review &amp; remote TPM</td>
</tr>
<tr>
<td>3 Preparation for Team convening in-country</td>
</tr>
<tr>
<td>4 Travel to country</td>
</tr>
<tr>
<td>5 Team Planning Meeting</td>
</tr>
<tr>
<td>6 In-brief with Mission</td>
</tr>
<tr>
<td>7 Workplan and Protocol briefing with USAID</td>
</tr>
<tr>
<td>8 In-brief with IHPB</td>
</tr>
<tr>
<td>9 Data Collection DQA Workshop (protocol orientation for all involved in data collection)</td>
</tr>
<tr>
<td>10 Prep / Logistics for Site Visits</td>
</tr>
<tr>
<td>11 Data collection / Site Visits (including travel to sites)</td>
</tr>
<tr>
<td>12 Data analysis</td>
</tr>
<tr>
<td>13 Debrief with Mission with prep</td>
</tr>
<tr>
<td>14 Stakeholder debrief workshop with prep</td>
</tr>
<tr>
<td>15 Depart country</td>
</tr>
<tr>
<td>16 Draft report(s)</td>
</tr>
<tr>
<td>17 GH Pro Report QC Review &amp; Formatting</td>
</tr>
<tr>
<td>18 Submission of draft report(s) to Mission</td>
</tr>
<tr>
<td>19 USAID Report Review</td>
</tr>
<tr>
<td>20 Revise report(s) per USAID comments</td>
</tr>
<tr>
<td>21 Finalize and submit report to USAID</td>
</tr>
<tr>
<td>22 508 Compliance Review</td>
</tr>
<tr>
<td>23 Upload Eval Report(s) to the DEC</td>
</tr>
</tbody>
</table>

| Total LOE per person | 47 | 40 | 32 | 28 |
| Total LOE            | 47 | 40 | 64 | 28 |

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

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

All twelve health districts in Karusi, Kayanza, Kirundo and Muyinga provinces. Sites within each district will be purposively selected in consultation with USAID.

### XV. LOGISTICS

**Visa Requirements**

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

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

<table>
<thead>
<tr>
<th>Name of Country</th>
<th>Type of Visa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burundi</td>
<td>□ Tourist</td>
</tr>
</tbody>
</table>
Clearances & Other Requirements

**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, but can request **Facility Access**. Please note that Facility Access (FA) requests processed by USAID/GH (Washington, DC) can take 4-6 months to be granted. If you are in a Mission and the RSO can grant a temporary FA, this can expedite the process. If FA is granted through Washington, DC, the consultant must pick up his/her FA badge in person in Washington, DC, regardless of where the consultant resides or will work.

If **Electronic Country Clearance (eCC)** is required, the consultant is also required to complete the **High Threat Security Overseas Seminar (HTSOS)**. HTSOS is an interactive e-Learning (online) course designed to provide participants with threat and situational awareness training against criminal and terrorist attacks while working in high threat regions. There is a small fee required to register for this course. [Note: The course is not required for employees who have taken FACT training within the past five years or have taken HTSOS within the same calendar year.]

If eCC is required, and the consultant is expected to work in country more than 45 consecutive days, the consultant must complete the one week **Foreign Affairs Counter Threat (FACT) course** offered by FSI in West Virginia. This course provides participants with the knowledge and skills to better prepare themselves for living and working in critical and high threat overseas environments. Registration for this course is complicated by high demand (must register approximately 3-4 months in advance). Additionally, there will be the cost for one week’s lodging and M&E to take this course.

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 (FA)
  Specify who will require Facility Access:

☐ Electronic County Clearance (ECC) (International travelers only)
  ☐ High Threat Security Overseas Seminar (HTSOS) (required with ECC)
  ☐ Foreign Affairs Counter Threat (FACT) (for consultants working on country more than 45 consecutive days)

☐ GH Pro workspace
  Specify who will require workspace at GH Pro:

☐ Travel -other than posting (specify): GH Pro will arrange all travel directly or through Eval Team Logistics Coordinator.

☐ Other (specify): All travel itineraries, including international and in country travel must be shared with USAID/Burundi in advance of arrival in Burundi. Details of hotels where all team members are staying must also be shared in advance. U.S. Citizens must register in the U.S. Embassy STEP program prior to arrival in country.

**XVI. GH PRO ROLES AND RESPONSIBILITIES**

GH Pro will coordinate and manage the evaluation/analytic 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/analytic 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.
• The evaluation team, with support from GH Pro, are responsible for making all in-country lodging and travel arrangements
• The evaluation team, with support from GH Pro, are responsible for all in-country administrative and logistic support needed, including setting appointments, printing, duplicating, etc.

XVII. USAID ROLES AND RESPONSIBILITIES
Below is the standard list of USAID’s roles and responsibilities. Add other roles and responsibilities as appropriate.

<table>
<thead>
<tr>
<th>USAID Roles and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>USAID</strong> will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:</td>
</tr>
</tbody>
</table>

**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, if needed.
- **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.

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

The **Evaluation/Analytic Final Report** must follow USAID’s Criteria to Ensure the Quality of the Evaluation Report (found in Appendix I of the USAID Evaluation Policy).
a. The report must not exceed 40 pages (excluding executive summary, table of contents, acronym list and annexes).
b. The structure of the report should follow the Evaluation Report template, including branding found here or here.
c. Draft reports must be provided electronically, in English, to GH Pro who will then submit it to USAID.
d. For additional Guidance, please see the Evaluation Reports to the How-To Note on preparing Evaluation Draft Reports found here.

Reporting Guidelines: The draft report should be a comprehensive analytical evidence-based evaluation/analytic report. It should detail and describe results, effects, constraints, and lessons learned, and provide recommendations and identify key questions for future consideration. The report shall follow USAID branding procedures. The report will be edited/formatted and made 508 compliant as required by USAID for public reports and will be posted to the USAID/DEC.

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

- Executive Summary: concisely state the most salient findings, conclusions, and recommendations (not to exceed 2 pages);
- Table of Contents, including list of tables & figures;
- Acronyms
- Evaluation Purpose and Evaluation Questions (1-2 pages)
- Project Background (1-3 pages)
- Evaluation/Analytic Methods and Limitations (1-3 pages)
- Findings (organized by Evaluation Questions)
- Conclusions
- Recommendations
- Based on the evaluation’s purpose and the findings, describe what remains to be done; what changes can be made in program design or implementation to result in more effective and/or efficient execution and improved results; identify potential new solutions to problems the project has faced; identify adjustments/corrections that need to be made; and recommend actions and/or decisions to be taken by management
- Lessons Learned: in terms of program implementation, coordination, and beneficiary satisfaction
- Annexes
  - Annex I: Evaluation Statement of Work
  - Annex II: Evaluation Methods and Limitations
  - Annex III: Data Collection Instruments
  - Annex IV: Sources of Information
    - List of Documents Reviewed
    - List of Persons Interviewed
    - List of places visited
    - List of types of FGD participants (e.g., “female beneficiaries in Province X,” “Senior IHPB Staff Member,” etc.)
    - Bibliography of Documents Reviewed
    - Databases
    - [Other, as needed]
  - Annex V: Disclosure of Any Conflicts of Interest
The evaluation methodology and report will be compliant with the USAID Evaluation Policy and Checklist for Assessing USAID Evaluation Reports.

--------------------------------
The Evaluation Report should exclude any potentially procurement-sensitive information. As needed, any procurement sensitive information or other sensitive but unclassified (SBU) information will be submitted in a memo to USIAD separate from the Evaluation Report.
--------------------------------
All data instruments, data sets (if appropriate), presentations, meeting notes and report for this evaluation/analysis will be submitted electronically to the GH Pro Program Manager. All datasets developed as part of this evaluation will be submitted to GH Pro in an unlocked machine-readable format (CSV or XML). The datasets must not include any identifying or confidential information. The datasets must also be accompanied by a data dictionary that includes a codebook and any other information needed for others to use these data. Qualitative data included in this submission should not contain identifying or confidential information. Category of respondent is acceptable, but names, addresses and other confidential information that can easily lead to identifying the respondent should not be included in any quantitative or qualitative data submitted.

GH PRO will submit a synthesis of all data used (project performance indicators, health information system statistics, demographic, and other survey data) in an Excel workbook or similar format to USAID/Burundi.

XIX. REFERENCE MATERIALS
Documents and materials needed and/or useful for consultant assignment, that are not listed above
### Annex 1: IHPB Indicators and Results as Reported in the FY 2015 Performance Plan and Report

<table>
<thead>
<tr>
<th>Performance Indicator</th>
<th>FY 2015 Target</th>
<th>FY 2015 Actual</th>
<th>FY 2016 Target</th>
<th>FY 2016 Actual</th>
<th>FY 2017 Target</th>
<th>FY 2017 Actual</th>
<th>FY 2018 Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1.6-61 Number of children who received DPT3 by 12 months of age in USG-Assisted programs</td>
<td>91,562</td>
<td>95,999</td>
<td>100,799</td>
<td>105,839</td>
<td>111,131</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1.6-64 Number of women giving birth who received uterotonics in the third stage of labor through USG-supported programs</td>
<td>7,765</td>
<td>15,224</td>
<td>7,765</td>
<td>15,985</td>
<td>16,784</td>
<td>17,624</td>
<td></td>
</tr>
<tr>
<td>Custom: Number of people trained in maternal/newborn health through USG-supported programs</td>
<td>100</td>
<td>142</td>
<td>100</td>
<td>75</td>
<td>75</td>
<td>75</td>
<td></td>
</tr>
<tr>
<td>Custom: Number of USG-supported facilities that provide appropriate life-saving maternity care (This will be defined as seven signal functions for BEmONC and nine signal functions for CEmONC)</td>
<td>50</td>
<td>46</td>
<td>50</td>
<td>50</td>
<td>54</td>
<td>58</td>
<td></td>
</tr>
<tr>
<td>Custom: Number of women reached with education on exclusive breastfeeding</td>
<td>112,000</td>
<td>98,612</td>
<td>112,000</td>
<td>103,543</td>
<td>108,720</td>
<td>114,156</td>
<td></td>
</tr>
<tr>
<td>3.1.7.1-1 Couple Years Protection in USG-supported programs</td>
<td>130,313</td>
<td>90,870</td>
<td>130,313</td>
<td>95,414</td>
<td>100,184</td>
<td>105,193</td>
<td></td>
</tr>
<tr>
<td>3.1.7.1-2 Percent of USG-assisted service delivery points (SDPs) that experience a stock out at any time during the reporting period of a contraceptive method that the SDP is expected to provide</td>
<td>1%</td>
<td>0.58%</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3.1.7.1-2a Numerator</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>3.1.7.1-2b Denominator</td>
<td>173</td>
<td>173</td>
<td>173</td>
<td>173</td>
<td>173</td>
<td>173</td>
<td></td>
</tr>
<tr>
<td>3.1.7.1-3 Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services</td>
<td>78%</td>
<td>80%</td>
<td>78%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td>3.1.7.1-3a Numerator</td>
<td>135</td>
<td>138</td>
<td>135</td>
<td>138</td>
<td>138</td>
<td>138</td>
<td></td>
</tr>
<tr>
<td>3.1.7.1-3b Denominator</td>
<td>173</td>
<td>173</td>
<td>173</td>
<td>173</td>
<td>173</td>
<td>173</td>
<td></td>
</tr>
</tbody>
</table>
## Annex 2. IHPB M&E Indicators and Results

Baseline figures, preliminary year two achievements (based on data available up to June 2015), year three targets, and life of project targets are presented below for each indicator.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline (^{22})</th>
<th>Preliminary Y2 Results (June 2015) (%) (^{23,24})</th>
<th>Y3 Target (^{9})</th>
<th>LOP Target (^{8})</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1.1) % of targeted audiences who report key behavioral pre-determinants at the individual, household, and community levels [MR]</td>
<td>TBD</td>
<td>n/a</td>
<td>n/a</td>
<td>+10%</td>
</tr>
<tr>
<td>1.1.2) % of targeted population who correctly report causes of specific illness [MR]</td>
<td>Set by health area (^{25})</td>
<td>n/a</td>
<td>n/a</td>
<td>+10%</td>
</tr>
<tr>
<td>1.1.3) % of the target population who recall hearing or seeing a specific HC intervention/message [FP/RH 3.1.7.2-1]</td>
<td>Set by health area (^{26})</td>
<td>n/a</td>
<td>n/a</td>
<td>TBD</td>
</tr>
<tr>
<td>1.1.4) # of health communication materials developed, field tested, and disseminated for use</td>
<td>0</td>
<td>0/8 (0%)</td>
<td>4</td>
<td>14</td>
</tr>
<tr>
<td>1.2.1) % of supported facilities that experience a stock-out at any time in the last three months [MR]</td>
<td>62% (^{27})</td>
<td>61%</td>
<td>35%</td>
<td>10%</td>
</tr>
<tr>
<td>1.2.2) % of USG-assisted service delivery points (SDPs) that experience a stock out of contraceptive methods that the SDP is expected to provide at any time during the reporting period [FP/RH 3.1.7.1-2]</td>
<td>38% (SARA)</td>
<td>0 (^{28})</td>
<td>0%</td>
<td>3%</td>
</tr>
<tr>
<td>1.2.3) % of health centers that meet minimum SCM standards</td>
<td>49% (^{29})</td>
<td>87% (^{30})</td>
<td>88%</td>
<td>90%</td>
</tr>
<tr>
<td>1.3.1) # of project interventions that address at least one gender theme (e.g. male norms, GBV, service equity, power imbalances within the household) [MR]</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>1.3.2) % of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services and products [MR]</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>6 (+50%)</td>
</tr>
</tbody>
</table>

---

\(^{22}\) Baseline and LOP targets noted as “TBD” are pending final results from IHPB HH survey.

\(^{23}\) Data for Y2 and Y3 targets noted as “n/a” are collected at baseline and endline only.

\(^{24}\) Indicators for which only preliminary Y2 actuals are provided did not have Y2 targets, as FAB data were not then available to inform their being set.

\(^{25}\) To be confirmed through PIRS


\(^{27}\) Source: IHPB SARA, 2014.

\(^{28}\) Source: District quarterly report for reproductive health products, April to June 2015.

\(^{29}\) Source: PBF Quality Report, Q1 2014.

\(^{30}\) Source: PBF Quality report, Q2 2015.
| Indicator                                                                 | Baseline 22 | Preliminary Y2 Results (June 2015) (%)
|                                                                         |          | Y3 Target 9 |
|                                                                         |          | LOP Target 8 |
| 1.3.3) % of target population reporting agreement with the concept that males and females should have equal access to social, economic, and political opportunities [MR] [GNDR-4] | 54% 31  | n/a          | n/a          | 80%          |
| 1.3.4) # of people completing an intervention pertaining to gender norms, that meets minimum criteria [GEND_NORM] | 0        | 0            | 75          | 400          |
| 1.3.5) # of persons receiving post-GBV care (Post-rape care, other post-GBV care, PEP) [GEND_GBV] | 102      | 108          | 150         | 180          |
| 1.3.6) # of health facilities providing PEP services                       | 7        | 21            | 27          | 34          |
| 2.0.15) Proportion of women attending antenatal clinics who receive IPTp2 under direct observation of a health worker | 0        | 50            | 70          | 80          |
| 2.0.16) Proportion of pregnant women receiving ANC who received ITNs         | 80% (116,160/144,739) | 79% (59,083/74,490) | 93          | 95          |
| 2.0.17) Proportion of children under five who received ITNs during measles immunization. | 86% (80,200/9,3122) | (90%)       | 94          | 95          |
| 2.0.18) Proportion of children under five with fever who received ACT within 24 hours of onset of fever 32 | 67% (20,666/31,060) | 71% (48,940/69,916) | 75          | 75          |
| 2.1.1) 2.0.16) Proportion of pregnant women receiving ANC who received ITNs | 75       | 91/92 (99%)   | 93          | 95          |
| 2.1.2) % of supported health centers with CHWs that provide core package of quality integrated health and support services | 0        | n/a          | n/a          | TBD          |
| 2.1.3) # of cases treated or referred by CHWs (malaria, diarrhea, ARI, FP, malnutrition, iron for pregnant women) | n/a 33   | n/a          | n/a          | n/a          |
| 2.1.4) % of health facilities that have functional CHW systems               | 11% (PBF 2014) | n/a          | 61%          | 75%          |
| 2.1.5) % of COSAs that meet defined functionality standards                 | 68%      | n/a          | 81%          | 85%          |
| 2.2.1) % of supported facilities that provide a core expanded a package of quality integrated health services [MR] | 0%       | n/a          | n/a          | +5%          |
| 2.2.2) % of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services | 26% (45/173) | 61% 34 (107/173) | 63% (109/173) | +10%          |

31 Source: IHPB HHS, 2015.
32 Denominator: # of children with fever received by CHW at HH level (69,916 while 6 six months in three CCM of malaria HDs). Numerator: # of children with fever treated with ACT by CHW (48940).
33Baseline, annual, and LOP targets could not be established as community reporting system is not sufficiently functional.
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>Preliminary Y2 Results (June 2015)</th>
<th>Y3 Target</th>
<th>LOP Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.3) Percent of facilities with at least 90% of clients reporting having received the appropriate core/expanded package of services [MR]</td>
<td>17%&lt;sup&gt;35&lt;/sup&gt; (26/153)</td>
<td>28%&lt;sup&gt;36&lt;/sup&gt; (34/119)</td>
<td>32%</td>
<td>+10%</td>
</tr>
<tr>
<td>2.2.4) Percent of supported facilities that perform to national technical and quality standards [MR]</td>
<td>10%&lt;sup&gt;37&lt;/sup&gt; (16/153)</td>
<td>56%&lt;sup&gt;38&lt;/sup&gt; (92/153)</td>
<td>60%</td>
<td>+10%</td>
</tr>
<tr>
<td>2.2.5) Percent of supported facilities that receive supportive supervision on a regular basis [MR]</td>
<td>98%&lt;sup&gt;39&lt;/sup&gt; (152/155)</td>
<td>76% (132/173)</td>
<td>98%</td>
<td>+ 5%</td>
</tr>
<tr>
<td>2.3.1) Percent of trained health providers, managers and CHWs who perform to a defined standard post-training&lt;sup&gt;39&lt;/sup&gt; [MR]</td>
<td>135</td>
<td>135/135 (100%)</td>
<td>TBD</td>
<td>+10%</td>
</tr>
<tr>
<td>2.3.2) Percent of supported health providers, managers and CHWs who have demonstrated improvement post-training [MR]</td>
<td>80%</td>
<td>970/1,212 (80%)</td>
<td>85%</td>
<td>+5%</td>
</tr>
<tr>
<td>2.3.3) Percent of trained health care staff who report positive attitudes about work and the work plan (composite indicator) [MR]</td>
<td>135/239 (57%&lt;sup&gt;41&lt;/sup&gt;)</td>
<td>66%</td>
<td>69%</td>
<td>+10% (76%)</td>
</tr>
<tr>
<td>2.3.4) Percent of health facilities with at least 80% of clients reporting satisfaction with services received [MR]</td>
<td>99%&lt;sup&gt;42&lt;/sup&gt;</td>
<td>100%</td>
<td>100%</td>
<td>+10%</td>
</tr>
<tr>
<td>2.3.5) Number of health care workers who successfully complete an in-service training program</td>
<td>1,347&lt;sup&gt;25&lt;/sup&gt;</td>
<td>#</td>
<td>#</td>
<td>TBD</td>
</tr>
<tr>
<td>2.3.6) Number of community health/para-social workers who successfully completed a pre-service training program</td>
<td>n/a</td>
<td>#</td>
<td>#</td>
<td>TBD</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain</th>
<th>DP</th>
<th>HC</th>
</tr>
</thead>
<tbody>
<tr>
<td>FP</td>
<td>48%</td>
<td>53%</td>
</tr>
<tr>
<td>MNCH</td>
<td>45%</td>
<td>49%</td>
</tr>
<tr>
<td>HIV</td>
<td>51%</td>
<td>53%</td>
</tr>
</tbody>
</table>

<sup>34</sup> Source: MPHFA Health Facility Monthly Reports, 2015.
<sup>35</sup> Source: PBF Community Survey, 2013.
<sup>36</sup> Source: PBF Community Survey, 2015.
<sup>37</sup> Source: SQG/PBF, 2014.
<sup>38</sup> Source: SQG/PBF, 2015.
<sup>39</sup>Defined as percent of health providers, managers, and CHWs who perform to a defined standard three months post-training, based on measurement of 10% of randomly selected health care workers who completed training (IHPB Draft PIRS, May 2015). IHPB-supported trainings include a pre- and post-training tests that serves as basis to calculate this indicator.
<sup>40</sup>Source: IHPB Excel-based monitoring of trainings, January to June 2015.
<sup>41</sup>Source: IHPB FQA, 2014.
<sup>42</sup>Source: PBF, January-December 2014.
## Indicator

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline&lt;sup&gt;22&lt;/sup&gt;</th>
<th>Preliminary Y2 Results (June 2015) (%)&lt;sup&gt;22, 24&lt;/sup&gt;</th>
<th>Y3 Target&lt;sup&gt;9&lt;/sup&gt;</th>
<th>LOP Target&lt;sup&gt;8&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria</td>
<td>DH 67%</td>
<td>76%</td>
<td>80%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>HC 90%</td>
<td>93%</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>3.1.2) Percent of supported facilities that have 70% of the required equipment to provide core/expanded packages of quality integrated health services [MR]&lt;sup&gt;43&lt;/sup&gt;</td>
<td>DH 38%</td>
<td>88%</td>
<td>98%</td>
<td>+5%</td>
</tr>
<tr>
<td></td>
<td>HC 57%</td>
<td>91%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>3.1.3) Number of supported testing facilities with capacity to perform clinical laboratory tests [PEPFAR LAB_CAP]</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>3.1.4) Number of PBF indicators supported by the project [MR]</td>
<td>7</td>
<td>7/7 (&lt;100%)</td>
<td>n/a&lt;sup&gt;44&lt;/sup&gt;</td>
<td>n/a&lt;sup&gt;30&lt;/sup&gt;</td>
</tr>
<tr>
<td>3.1.5) Percent of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis [MR]</td>
<td>100%</td>
<td>100%/100% (100%)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>3.2.1) Percent of facilities that maintain timely reporting [MR]</td>
<td>95.8%</td>
<td>99.7%</td>
<td>99.7%</td>
<td>+5%</td>
</tr>
<tr>
<td></td>
<td>(184/192)</td>
<td>(191/192)&lt;sup&gt;45&lt;/sup&gt;</td>
<td>(191/192)</td>
<td></td>
</tr>
<tr>
<td>3.2.3) Percent of provinces, districts and facilities that demonstrably use facility- and community-level data for timely decision making [MR]</td>
<td>151/173 (87%)</td>
<td>n/a</td>
<td>90%</td>
<td>+10%</td>
</tr>
<tr>
<td></td>
<td>SARA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3.1) Number of supported CSOs with demonstrated improvements in key technical and organizational capacity areas (e.g. quality of services, service coverage, governance, financial management, procurement, human resources, project and information management, sustainable funding and related areas and related areas) [MR]</td>
<td>0</td>
<td>n/a</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3.3.2) Number of CSOs that transition (graduate) and qualify to receive direct USAID funding [MR]</td>
<td>0</td>
<td>0/3 (0%)</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>3.3.6) Number of organizational capacity assessments completed with supported CSOs</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>15</td>
</tr>
</tbody>
</table>

<sup>43</sup> To calculate these indicators, we compared what health facilities had asked and what we gave to them.

<sup>44</sup> Per PEPFAR 2015 COP IHPB will no longer be supporting PBF in Y3-5.

<sup>45</sup> Source: GESIS

<sup>46</sup> Y2 actuals as of June 2015. Complete Y2 data to be reported in late 2015.
ANNEX 3: The Integrated Package of Health Services Provided by the Project

Health services to be provided within health facilities:

**HIV/AIDS prevention and treatment**, including:
- HIV testing and counseling (HTC) as the entry point to care, treatment, and support services
- Family-focused PMTCT
- STI and opportunistic infection (OI) screening and treatment
- Clinical youth- and family-friendly comprehensive Positive Prevention services
- PEP for post-rape victims
- Expanded condom, basic care package for PLHIV, and home-based care package distribution

**Malaria prevention and treatment**, including:
- Counseling on use of nets and prompt care-seeking
- Diagnosis and treatment of both uncomplicated and severe malaria episodes
- Continuous ITN distribution (as ITNs become part of the essential medicine package)

**Family planning and reproductive health services**, including:
- Quality counseling and provision of information to assure informed choice
- Provision of a wide range of contraceptive methods, including: male and female condoms, oral contraceptives, injectable contraceptives, long-acting (implants, IUDs,) and permanent (tubal ligation, vasectomy) methods
- Provision of natural methods of family planning as appropriate
- Provision of counseling, care and treatment services for victims of GBV
- Post-abortion care
- Other reproductive health services (e.g. treatment of infertility; reproductive tract infections)

**Comprehensive pregnancy and delivery services**, including:
- Focused antenatal care, including:
- Counseling and testing for HIV and syphilis and prevention of mother-to-child transmission of HIV
- Preventive treatment of malaria in pregnancy and IPTp (if becomes policy), including free distribution of ITNs in ANC clinics
- Screening for anemia, mental health problems/or symptoms of stress or domestic violence and counseling
- Preventive measures (e.g. tetanus toxoid immunization; de-worming, iron; consistent use of folic acid)
- Recognition and management of pregnancy related complications, particularly pre-eclampsia
- Birth and emergency preparedness planning
- Early detection and treatment of complications and existing diseases
- Comprehensive delivery care, including:
- Basic emergency obstetric and neonatal care or comprehensive emergency obstetric and neonatal care as appropriate to level of care, including management of pre-eclampsia, active management of the third stage of labor (AMSTL), essential newborn care, and immediate postpartum care of the mother
- Prevention of post-partum hemorrhage
- Postnatal care of infant and mother, including post-natal family planning
**Integrated Management of Newborn and Child Illness**, including:
- Essential newborn care
- Diagnosis and treatment of uncomplicated and severe malaria episodes
- Diagnosis and management of under-nutrition, moderate acute malnutrition and referral if needed
- Diagnosis and management of acute respiratory infections
- Diagnosis and management of diarrheal cases
- Counseling care givers on use of nets and prompt care seeking behavior
- Prevention of illness through education on the importance of immunization, micronutrient supplementation, and improved nutrition, especially oral rehydration therapy (ORT), breastfeeding, and infant feeding

**Well-Child Care**, including:
- Immunization according to national standards
- Growth monitoring and nutritional status monitoring
- Free distribution of ITNs in EPI clinics and counseling care givers on correct and consistent use

**Cross-cutting approaches at the facility level**, including:
- Leveraging the ANC platform for PMTCT, FP, malaria in pregnancy, and emergency obstetric and neonatal care
- FP, MNCH, PMTCT, and malaria integrated into child health services
- Integration of HTC into in- and outpatient clinics and services
- Counseling within the facility with integrated messages
- Pharmaceutical management at the health facility level
- Expand ITN distribution to community at large, as directed by GOB policy (yet to be finalized)
- Integration of health services into other health and non-health resources and programs (e.g. income generation; water and sanitation; food and nutrition)

**Integrated package of quality health services to be provided at the community level:**

**Community-based services for specific target audiences**, including:
- Community-based Positive Prevention
- Home-based care
- Services and support for OVC
- Malaria diagnosis and treatment for children under five
- Community-based condom, ITN, ORS, point-of-use water treatment, and FP distribution
- Referrals to complementary services (e.g. food; agriculture; nutrition; economic strengthening)
- Implementation support for behavioral interventions/social and behavior change communications (SBCC) to targeted audiences
- Implementation of male involvement strategies

**Community case management**, including:
- MNCH and community-IMCI
- Positive Prevention with PLHIV
- Uncomplicated malaria in select areas
- Treatment adherence
- Product distribution, including condoms, ITNs, ORS/zinc, point-of-use water treatment, and FP
- Referrals to complementary services
ANNEX B. METHODOLOGY

GH PRO Evaluation Workplan: IHPB Performance Evaluation: Methodology

Title: Integrated Health Project Burundi Performance Evaluation


Purpose: The purpose of this performance evaluation is to assess progress that the Integrated Health Project Burundi (IHPB) has made to date in achieving its objectives and document the effectiveness of the project’s approaches and responsiveness to integrating and improving health behaviors, services and systems. The evaluation will help USAID/Burundi identify how well the implementer has achieved expected project results as well as examine key technical and management systems strengths, weaknesses, opportunities, and threats in the implementation of the IHPB.

Evaluation Questions:

<p>| | |</p>
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<thead>
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<tbody>
<tr>
<td>5.</td>
<td>To what extent has the IHPB achieved its intended objective to increase quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?</td>
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<tr>
<td>6.</td>
<td>To what extent has the IHPB achieved its intended objectives to strengthen health capacity and systems?</td>
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<tr>
<td>7.</td>
<td>How well is the integration of health services approach working in the covered area?</td>
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<tr>
<td>8.</td>
<td>What lessons learned can inform project management for the remainder of the project life and future potential follow-on designs?</td>
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</tbody>
</table>

Target audience(s) for this evaluation: The primary audience for this evaluation is the USAID/Burundi Health Office. Other users include the USAID Washington Global Health Bureau, USAID Presidential Malaria Initiative, and the Office of the Global AIDS Coordinator who have all contributed funds to implement the project. Other key audiences include the Burundi Country Representative, USAID/Burundi Program Office, Embassy Bujumbura Front Office, in the context of their collaboration to implement the IHPB, and USAID/Burundi.

Methodology
Methods:
1. Desktop preparation
   a. Evaluation Launch Briefing: USAID and IHPB contractors;
      i. **Description:** Provided an opportunity for all technical stakeholders to review initial requirements and key questions as specified in the scope of work. As the **first two evaluation deliverables**, the launch briefings were held on August 22\textsuperscript{nd} (USAID) and August 25\textsuperscript{th} (IHPB).
   b. Virtual Team Planning meetings (vTPM);
      i. **Description:** Provides an opportunity for evaluation team members to collaborated via the internet on a review of the scope of work, on the preliminary selection of survey sites and on the preparation of a draft workplan and draft survey documents;
   c. Review of documentation;
      i. **Description:** Provides an opportunity for evaluation team members to understand the IHPB’s technical framework and its progress in implementing the IHPB;
d. Preparation and submission to USAID of draft evaluation workplan;
   i. **Description:** Communicating through vTPM and based on the team’s review of the
      IHPB evaluation’s scope of work, the evaluation team will prepare a draft workplan.
      As the **2nd deliverable**, the draft workplan was delivered to USAID/B on September
      1, 2016.

e. Preparation of field survey instruments;
   i. **Description:** Communicating through vTPM and based on the team’s review of the
      IHPB evaluation’s scope of work and on available documentation, the evaluation team
      will prepare a draft set of survey instruments. The instruments will include a series of
      Key Informant Interview (KII) templates focused on several different audiences (i.e.
      health center senior staff; district health authorities; national-level Ministry of Public
      Health authorities; IHPB senior officials, allied development partners; and USAID
      technical officers) and Focus Group Discussion (FGD) templates focused on IHPB
      partners, health center staff, community health workers, allied community service
      organizations (CSOs), and health center clients. In addition, the evaluation team will
      develop an observation check list to be employed during the team’s visit to survey
      sites. As the **3rd deliverable**, the draft field survey documents, including a key
      informant interview (KII) template, a focus group discussion (FGD) template and an
      on-site quantitative observation checklist were delivered to USAID/Burundi on
      September 1, 2016. Following the team’s first in-country team planning meeting
      (TPM), the survey instruments were finalized and approved by USAID/B prior to the
      team’s departure for the field on September 12, 2016.

f. Selection of sites
   i. **Description:** Working in concert with USAID and IHPB staff, the evaluation team
      completed its approved selection of sites on September 8, 2016. In reaching
      agreement on the evaluation’s selection of sites, USAID/Burundi and the evaluation
      team recognized that, given the fact that only 12 days were available for field visits, it
      would not be possible to visit all sites as part of the IHPB’s qualitative performance
      evaluation. Accordingly, in consulting the IHPB’s annual and quarterly reports, USAID
      and the evaluation team agreed on the following preliminary selection criteria for
      selecting among the IHPB’s 176 potential sites in the IHPB’s four client
      provinces and 12 districts (Karusi Province: Buhiga and Nyabikere Districts; Kayanza
      Province: Kayanza, Musema, and Gahombo Districts; Kirundo Province: Kirundo,
      Busoni, Mukenke, and Vumbi Districts; and Muyinga Province: Muyinga, Giteranyi, and
      Gashoho Districts):

      - Sites with reported high performance (i.e. provincial hospitals)
      - Sites with reported average performance (i.e. district hospitals)
      - Sites with reported low performance (i.e. health centers and IHPB-supported
        civil society organizations (CSOs) service delivery centers

      In addition, with reference to health centers, the criteria for selection also called
      for considering sites from among those health centers that had reportedly
      worked with the IHPB in introducing quality improvement approach measures
      as well as those that did not.

      Based on the above initial selection criteria and on the IHPB’s health facility data
      base, the evaluation team worked with USAID to apply the process of
      convenience sampling in arriving at a final selection of 23 IHPB-supported

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47 In applying convenience sampling, “the most common of all sampling techniques,” the evaluation team makes no
claim that the statistics apply to all IHPB client facilities. As agreed to by USAID/Burundi, the team used convenience
sampling to help in “documenting that a particular quality of a substance or phenomena [e.g. enhanced quality in the
delivery of services through integration] occurs within a given sample” (https://explorable.com/convenience-sampling).
facilities (three provincial hospitals, three district hospitals, 15 health centers, and three IHPB-supported civil society organization’s service delivery facilities).

2. In Country preparation
   a. In-country team planning meetings (TPM):
      i. **Description:** Provided an opportunity for the evaluation team to finalize its review of the scope of work, to identify issues for discussion with USAID during the Mission’s in-briefing. In a series of subsequent TPMs, the evaluation team, following discussions with USAID and IHPB staff, will adjust its workplan, its formulation of survey instruments, its selection of sites and its selection of survey respondents. The team also developed an electronic data sheet for entering the results of the quantitative on-site observation checklists. As scheduled, the evaluation team completed its TPM orientation and planning process on September 10, 2016 prior to its departure for the field.
   
   b. In-briefings and discussions with USAID:
      i. **Description:** Provided an opportunity for the evaluation team to work with USAID technical staff in an in-depth review of the scope of work. During the in-brief and subsequent discussions with the USAID, evaluation team members finalized the draft workplan and draft survey instruments. The team also worked with USAID and IHPB in a review and finalization of the list of survey sites, the list of respondents and groups to be included in KII’s and FGDs, the timeline, and the workplan. (4th - 7th deliverables). The evaluation team completed this process on September 9, 2016 prior to its departure for the field.
   
   c. In-briefings and discussions with IHPB staff:
      i. **Description:** Provided an opportunity for the evaluation team to work with IHPB technical staff in an in-depth review of project workplans and annual performance records. During the in-brief and subsequent discussions with the IHPB, evaluation team members worked with IHPB staff in a review and finalization of survey sites (including an identification of alternate sites) and of the list of respondents and groups to be included in KII’s and FGDs. The evaluation team completed this process on September 7, 2016 prior to its departure for the field. (8th deliverable);
   
   d. Site visit scheduling:
      i. **Description:** Based on an agreement on sites and on information provided by IHPB staff, the evaluation team’s logistics coordinator communicated with district, health center, and CSO representatives to schedule meetings and visits. The logistics coordinator also engaged the services of a vehicle and driver for each of the two survey teams ensuring that each driver selected for the teams had accurate information on the location of each evaluation field site.
   
   e. Final preparation of site visit teams (2 sub-teams)
      i. **Description:** As a final step prior to departing for the site visits, the two sub-teams collaborated on reviewing all requirements associated with the site visits, including agreement on the responsibilities of each sub-team leader, communications modalities between the two teams and the process for ensuring that all survey data was electronically recorded and preserved while in the field.

3. Site Visits
   a. Collection of field data
      i. **Description:** At each selected site, the two survey sub-teams:
         1. Met with the district health authority and, if possible, engage the district official in a KII;*
         2. Carried out a KII with a selected site’s director;*
         3. Carried out an FGD with a selected site’s service delivery staff;*
4. Carried out observations based on the observation check list;*
5. Carried out, if feasible, a FGD with clients;*
6. Carried out, if feasible, a FGD with an allied CSO*

* At the end of each day in the field, each sub-team ensured that the results of all KII's and FGD's were electronically recorded on data sheets developed during TPMs.

b. Communication with USAID and among the two sub-teams.
   i. **Description:** The team leader emailed a weekly progress report to USAID (9th deliverable). Both sub-team leaders exchanged emails at the end of each field day. Daily reports summarized progress on the daily schedule and identified challenges encountered and solutions adopted to respond to identified challenges.

4. Data Analysis
   a. Development of electronic data files
      i. **Description:** As a first step in the analytical process, the evaluation team prepared a master file that integrated the electronic data recorded during each day of the site visits.
   b. Analysis of Quantitative Data
      i. **Description:** Using Excel in the development of an analytical spreadsheet to facilitate analysis of the team's on-site observations' quantitative data, the team developed a series of summary tables that were used to validate KII and FGD findings and to determine the extent to which IHPB's reported performance was supported by on-site observations.
   c. Analysis of Qualitative Data
      i. **Description:** Qualitative data entered into the initial electronic master file of key informant interviews and focus group discussions (see Paragraph 4.a.i above) was summarized and compiled in a second master summary file designed to mask the identity of the respondents. This second master file was then organized thematically based on the four questions posed in the evaluation's scope of work. In addition, the thematic summaries of qualitative data was used to expand upon and validate findings associated with the on-site observation quantitative analysis and with the team's review of project-related documents and reports.
   d. Preparation of presentation to USAID and stakeholders of preliminary findings
      i. **Description:** The evaluation team prepared PowerPoint presentations for both USAID and IHPB staff and stakeholders. The presentations focused on preliminary findings associated with the scope of work's four principal questions.

5. Presentation and discussions of preliminary findings to USAID and to stakeholders including contractors
   i. **Description:** As scheduled, the two PowerPoint presentations and accompanying discussions were facilitated by the team on October 5th and 6th (10th and 11th deliverables). Comments and observations offered by participants during these two presentations were subsequently used to adjust and expand upon the evaluation team's preliminary findings as part of the report-writing process (see Paragraph 5 below).

6. Desktop report writing
   i. **Description:** Following the team leader's October 7, 2016 departure from Burundi, the evaluation team spent ten working days preparing the evaluation report's first draft. The draft report built on the team's preliminary findings presented in its PowerPoint presentations and on feedback provided by participants in the out-briefings. As specified in the scope of work, the report included the following:
      1. An executive summary that will concisely state the most salient findings, conclusions, and recommendations;
      2. A statement of the evaluation's purpose and its evaluation questions;
      3. A summary of the project's background;
4. A description of the evaluation’s methodology and limitations;
5. An in-depth discussion of the evaluation’s findings organized with reference to the scope of work’s four evaluation questions;
6. Conclusions;
7. Recommendations; and
8. Lessons Learned.

7. Submission of 1st draft report to USAID
   i. Description: On November 3, 2016, the evaluation team submitted its 1st draft report through GH Pro for USAID’s review. (12th deliverable)

8. Revision of Draft Report and Submission of Final Report to GH Pro
   i. Description: Based on USAID’s review of its 1st draft, the evaluation team prepared and submitted a final revised version of its 1st draft to GH Pro for final editing and for subsequent submission to USAID/B. (13th deliverable) As part of this final evaluation team deliverable, the evaluation team provided copies of all relevant data instruments and data sets in an unlocked machine-readable format.

9. GH Pro final editing of evaluation report and submission to USAID
   i. Description: Following the evaluation team’s submission of its final report and of all data instruments and data sets, GH Pro will engage with USAID in the process associated with final editing/proofing of the team’s report. The time period assigned to this final task will be determined.

Ethical Considerations & Human Subject Protection:

All Key Informant Interviews and Focus Group Discussions will include a standard informed consent provision which will be agreed upon prior to an interview or discussion. Those participants who do not consent to participate in an interview or a discussion will be asked to withdraw so that the interview or discussion can begin. In addition, no qualitative data included in the report will contain identifying information. Finally, no data presented in the report will include data of a confidential or sensitive nature from the perspective either of the United States Government or the Government of Burundi.
<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Information Required and Source(s)</th>
<th>Methodology</th>
<th>Sample</th>
<th>Limitations</th>
<th>Data Analysis</th>
<th>What will this evaluation allow the evaluator to say</th>
</tr>
</thead>
</table>
| **1.** To what extent has the IHPB achieved its intended objective to increase quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)? | **1.** Annual and Quarterly Reports and PIRS: Available from IHPB records.  
3. Provider and stakeholder perceptions: Obtained through KIIs  
3. Field observations: Achieved during site visits using illustrative check list. | Answers will be based on: 1. Examination of IHPB records; of health facility records to the extent available and feasible; and of client use observations.  
2. KIIs with providers and stakeholder (including MOH and District Hlth Officers). | Criteria for site sample selection will include:  
- Consideration for USAID priority sites (if applicable)  
- Balanced representation among IHPB districts (if feasible given constraints – Please see next column);  
- Balanced representation among high, average and low performing facilities based on IHPB reports;  
- "Convenience sampling" (Please see footnote 1 above) to account for constraints associated with logistics, HR and time available for site visits. | Design limitations include the following considerations:  
1. Limitations in human resources to carry out extensive site visits;  
2. Logistical constraints;  
3. Limitations in time available for site visits;  
4. Emphasis on qualitative vs. quantitative analyses  
Impact on evaluation’s findings: Given the above limitations:  
1. The findings will have limited statistical rigor except with reference to accounting for IHPB’s achievement-to-date of targets;  
2. The findings will be limited in scope based on the evaluation’s coverage of a small subset of IHPB client facilities;  
2. The findings, based largely on providers’ clients’ and stakeholder’s perceptions documented through KIIs and FGDs, will be necessarily subjective rather than objective. | Data will be managed and analyzed through:  
1. Quantitative analysis of IHPB and health facility records;  
2. Qualitative analysis of KII and FGDs and field observations electronically recorded on a daily basis and organized around major themes.  
3. Triangulation of quantitative and qualitative analyses. | It is expected that data collection and analysis associated with this question will provide findings relevant to recommendations on ways in which the IHPB can adjust its subsequent workplans to more effectively respond to the project’s intended objective. |

| **2.** To what extent has the IHPB achieved its intended objectives to strengthen health capacity and systems? | **1.** Baseline information and performance indicator reference sheets (PIRS): Available from IHPB records.  
2. Provider and key stakeholder perceptions: Obtained through KIIs. | Answers will be based on:  
1. Examination of project records;  
2. KIIs with providers and key stakeholders. | Data will be managed and analyzed through:  
1. Quantitative analysis of IHPB and health facility records;  
2. Qualitative analysis of KII and FGDs and field observations electronically recorded on a daily basis and organized around major themes.  
3. Triangulation of quantitative and qualitative analyses. | It is anticipated that data collection and analysis associated with this question can assist the project in increasing its focus on strengthening health capacity and systems. |
<table>
<thead>
<tr>
<th>Evaluation Question</th>
<th>Information Required and Source(s)</th>
<th>Methodology</th>
<th>Sample</th>
<th>Limitations</th>
<th>Data Analysis</th>
<th>What will this evaluation allow the evaluator to say</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. How well is the integration of health services approach working in the covered area?</td>
<td>1. Client use: Obtained on-site through FGDs and observations. 2. Provider perceptions: Obtained on-site through KIIs with senior staff and FGDs with service delivery staff.</td>
<td>Answers will be based on: 1. Site visit FGDs (clients, service delivery staff, and CSOs); 2. KIIs with senior health service staff.</td>
<td>See above Page 1</td>
<td>See above Page 1</td>
<td>Data will be managed and analyzed through qualitative analysis of FGDs and KIIs around major themes.</td>
<td>It is anticipated that data collection and analysis associated with this question will assist the project in responding to challenges linked to more effective integration of services.</td>
</tr>
<tr>
<td>4. What lessons learned can inform project management for the remainder of the project life and future potential follow-on designs?</td>
<td>1. Provider and key stakeholder perceptions obtained through KIIs 2. Annual and Quarterly Reports: Available from IHPB records 3. IHPB staff perceptions, KIIs/FGDs with IHPB staff.</td>
<td>Answers will be based on: 1. Provider and key stakeholder (including MOH and USAID) KIIs; 2. IHPB staff KIIs and FGDs; 3. Examination of annual and quarterly reports’ issue identification.</td>
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<td>Data will be managed and analyzed through: 1. Qualitative analysis of FGDs and KIIs around major themes 2. Triangulation of qualitative analysis with analysis of project data.</td>
<td>It is anticipated that data collection and analysis associated with this question will assist the project in its improvement of project management while also assisting USAID in future project design.</td>
</tr>
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### Timeline: Integrated Health Project-Burundi (IHPB) Performance Evaluation

<table>
<thead>
<tr>
<th>Activity/Task</th>
<th>Week</th>
</tr>
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<tbody>
<tr>
<td>Launch briefing of USAID and IHPB</td>
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<tr>
<td>Desktop review and virtual Team Planning meetings (vTPM)</td>
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<tr>
<td>Submission of preliminary workplan and survey instruments to USAID</td>
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<td>Preliminary site selection</td>
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<td>Team leader (TL) arrival in Burundi</td>
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<td>In-briefings from USAID and IPs</td>
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<tr>
<td>Task</td>
<td>Week 1</td>
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<tr>
<td>Team preparation of final workplan and survey instruments</td>
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<td>Final site selection</td>
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<td>Preparation for site visits</td>
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<td>Site Visits</td>
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<td>Data Analysis</td>
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<td>Preparation of preliminary findings</td>
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<td>Presentation of preliminary findings</td>
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<td>Departure of TL from Burundi</td>
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<td>Desktop report writing</td>
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<td>Team submission of 1st Draft</td>
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<tr>
<td>USAID Review of 1st Draft</td>
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<tr>
<td>Team revision of 1st Draft</td>
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<tr>
<td>Team submission of final draft to GH Pro</td>
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<tr>
<td>GH Pro final report editing and submission to USAID</td>
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<tr>
<td><strong>Team Members</strong></td>
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<tr>
<td>Name</td>
<td>Role</td>
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</tr>
<tr>
<td>William Emmet</td>
<td>Team Leader</td>
</tr>
<tr>
<td>Audace Niyongere</td>
<td>Technical Specialist</td>
</tr>
<tr>
<td>Faustin Habimana</td>
<td>Local evaluator</td>
</tr>
<tr>
<td>Diane Mpinganzima</td>
<td>Local evaluator</td>
</tr>
<tr>
<td>Annick Irakoze</td>
<td>Logistics coordinator</td>
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ANNEX C. IHPB MIDTERM PERFORMANCE EVALUATION SURVEY INSTRUMENTS

Integrated Health Project Burundi (IHPB)
Performance Evaluation
August 17 – December 1, 2016

Managed by Global Health Program Cycle Improvement Project (GH Pro)
Key Informant Interview Guidelines – Health Service Managers
Question Guidelines

Instructions to Moderator:

A. Use the following questions to guide the flow of the interview;
B. Give the informant sufficient time to respond to each question;
C. If indicated, allow the discussion to expand to issues introduced by the informant;
D. If the respondent does not seem to have an answer to a question, record no response and move on to the next question;
E. When taking notes, maintain eye contact with the respondent as much as possible

Instructions to Moderator: The informant’s answer to the following question will help you determine the extent to which you can proceed with subsequent questions. For example, if the informant indicates that s (he) has limited knowledge of the IHPB, you will need to find a way to politely end the interview.

1. How would you describe your experience working with the IHPB program and your knowledge of the IHPB?

Instructions to Moderator: Based on the respondent’s experience, knowledge and engagement with the IHPB, proceed with the following questions.

2. Under the evaluation’s statement of purpose, we are being asked to address:

To what extent has the IHPB achieved its intended objective to increase quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

Moderator’s introduction to the questions in this section: Your response to the following questions will assist the evaluation team in assisting USAID and the Government of Burundi in accurately and reliably evaluating the extent to which the four service areas have achieved a level of quality and the extent to which the four service areas have been integrated. Your response on this issue will also assist the evaluation team in determining ways in which to build on progress achieved under the project.
2.1 From your perspective, what aspects of the IHPB Project have been most effective? In what ways have they been effective? Why have they been effective?

2.2 From your perspective, what, if anything, is innovative about the IHPB’s approach to increasing the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

2.3 From your perspective, what is your assessment of “best practices” instituted by the IHPB in addressing ways in which to increase the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

2.4 From your perspective with reference to the IHPB, what are the least successful approaches applied by the program towards addressing ways in which to increase the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

2.5 Have you observed that IHPB incorporated principles of gender equality and empowerment in the design and implementation of activities, such as through ensuring an inclusive approach to addressing any gender specific barriers to increasing the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

3. As a second line of inquiry, we are being asked to address the following issue:

To what extent has the IHPB achieved its intended objectives to strengthen health capacity and systems?

Moderator’s introduction to the questions in this section: Your response to the following questions will assist the evaluation team in assisting USAID and the Government of Burundi in accurately and reliably evaluating the extent to which the IHPB has strengthened health capacity and systems. Your response on this issue will also assist the evaluation team in determining ways in which to build on progress achieved under the project.

3.1 In what way has the IHPB contributed to capacity building of health systems?

3.2 In what way has the IHPB contributed to capacity building of HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services?

3.3 From your perspective with reference to the IHPB, have there been any barriers to the ability of the IHPB to capacity building of health services and systems? If so, how would you describe these barriers and their impact, actual or potential, on the project’s execution?

3.4 What has the project done to respond to the barriers?

3.5 From your perspective with reference to the IHPB, what issues or barriers to improving the capacity of health services and systems have remained unresolved in the IHPB’s execution of its project? How could these issues and barriers be resolved?

4. As a third line of inquiry, we are being asked to address the following issue:

How well is the integration of health services approach working in the covered area?
Moderator’s introduction to the questions in this section: Your response to the following questions will assist the evaluation team in assisting USAID and the Government of Burundi in accurately and reliably evaluating the effectiveness of the IHPB’s approach to integration of health services. Your response on this issue will also assist the evaluation team in determining ways in which to build on progress achieved under the project.

4.1 How would you define integration and its importance to improved HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services at patient diagnosis and treatment and at management levels?

4.2 To what extent has the program been effective in integrating HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services at patient diagnosis and treatment and at management levels? In what way collaboration could be improved among services and in-service management?

4.3 What has been the impact of this program integration?

4.4 What steps should be taken in the future to increase effective integration of HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services at patient diagnosis and treatment and management levels?

5. As a fourth and final line of inquiry, we are being asked to address the following issue:

What lessons learned can inform project management for the remainder of the project life and future potential follow-on designs?

Moderator’s introduction to the questions in this section: Your response to the following questions will assist the evaluation team in assisting USAID and the Government of Burundi in determining what lessons have been learned during the project’s first three years of execution. Your response on this issue will also assist IHPB project management in strengthening its activities during its remaining two years (2017-2018). Finally, your responses to the following question will assist the evaluation team in providing recommendation on future potential follow-on designs.

5.1 Looking back at the IHPB’s first three years of project implementation, what lessons have been learned that will help inform project management for the remainder of the project’s life?

5.2 In the context of the IHPB, how would you define sustainability?

5.3 Based upon your definition of sustainability, what aspects of the project are sustainable? What has contributed to their sustainability?

5.4 Based upon your definition of sustainability, what aspects of the project are not sustainable? Why, in your opinion, are these aspects of the project not sustainable?

5.5 With reference to the IHPB final two years of operation, what actions or interventions would you recommend to build upon and improve prospects for the sustainability of IHPB activities?

5.6 If you were to be involved in the design of a project to continue after the IHPB is completed in September 2018:

5.6.1 What would be your principal goals and objective for such a project?
5.6.2 What parameters (e.g., geographical, focus, technical components, cost, staffing, etc.) would define such a project?

5.6.3 Do you think that the geographic focus of the IHPB project is appropriate? Are there provinces or districts where the project is currently not working but in which it could potentially have a significant positive impact?

(To moderator: The final question is designed to give the key informant an opportunity to address additional points of importance that were not covered during the interview. Care should be taken to encourage the respondent to respond as openly and as frankly as possible in providing this additional input).

6. The purpose of this performance evaluation is to assess progress that the Integrated Health Project Burundi (IHPB) has made to date in achieving its objectives and to document the effectiveness of the project's approaches and responsiveness to integrating and improving health behaviors, services and systems. The evaluation is also expected to provide recommendations for the design of a possible successor to the IHPB project. In addition to points that we have already discussed, do you have additional observations or recommendations that will assist the evaluation team in responding to the overall evaluation objective?
Performance Evaluation
August 17 – December 1, 2016
Mid-Term Evaluation of the Integrated Health Project/Burundi (IHPB)
Hospital and Health Center Service Providers
Focus Group Discussion Guidelines
Question Guidelines

Instructions to Moderator: The informant’s answer to the following question will help you determine the extent to which you can proceed with subsequent questions. For example, if certain participants indicate that they have limited knowledge of the IHPB, you will need to focus on those participants who have indicated that they have knowledge of the IHPB. However, even if some participants indicate that they limited knowledge of the IHPB, they may be able to answer respond to some of the questions. It is important to involve all participants in the discussion as much as possible.

1. How would you describe your experience working with the IHPB program and your knowledge of the IHPB?

2. From your perspective, has IHPB assistance increased the quality of health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)? In what way has IHPB assistance been most effective? In what way had IHPB assistance been least effective?

3. From your perspective, how has your capacity as a health provider been increased by IHPB assistance? How could your capacity be further increased?

4. From your perspective, how has the capacity of your health service been increased by IHPB assistance? How could the capacity of your health service be further increased?

5. From your perspective, has IHPB’s approach to integration worked in your health facility? What have been the strongest aspects of IHPB’s approach to integration? What have been the principal challenges associated with IHPB’s approach to integration?

6. From your perspective, what lessons have been learned as a result of IHPB’s focus on the quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH);

7. The purpose of this performance evaluation is to assess progress that the Integrated Health Project Burundi (IHPB) has made to date in achieving its objectives and to document the effectiveness of the project’s approaches and responsiveness to integrating and improving health behaviors, services and systems. The evaluation is also expected to provide recommendations for the design of a possible successor to the IHPB project. In addition to points that we have already discussed, do you have additional observations or recommendations that will assist the evaluation team in responding to the overall evaluation objective?
Integrated Health Project Burundi (IHPB)
Performance Evaluation
August 17 – December 1, 2016
Key Informant Interview Guidelines
District Medical Officer
Question Guidelines

Instructions to Moderator: The informant’s answer to the following question will help you determine the extent to which you can proceed with subsequent questions. For example, if the informant indicates that s (he) has limited knowledge of the IHPB, you will need to find a way to politely end the interview.

1. How would you describe your experience working with the IHPB program and your knowledge of the IHPB?

2. Under the evaluation’s statement of purpose, we are being asked to address:

   To what extent has the IHPB achieved its intended objective to increase quality and use of integrated health and support services for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

   Moderator’s introduction to the questions in this section: Your response to the following questions will assist the evaluation team in assisting USAID and the Government of Burundi in accurately and reliably evaluating the extent to which the four service areas have achieved a level of quality and the extent to which the four service areas have been integrated. Your response on this issue will also assist the evaluation team in determining ways in which to build on progress achieved under the project.

   2.1 From your perspective, what aspects of the IHPB Project have been most effective? In what ways have they been effective? Why have they been effective?

   2.2 From your perspective with reference to the IHPB, what are the least aspects of the IHPB’s assistance to your district?

3. As a second line of inquiry, we are being asked to address the following issue:

   To what extent has the IHPB achieved its intended objectives to strengthen health capacity and systems?

   3.1 In what way has the IHPB contributed to capacity building of health systems?

   3.2 From your perspective with reference to the IHPB, have there been any barriers to the ability of the IHPB to capacity building of health systems? If so, how would you describe these barriers and their impact, actual or potential, on the project’s execution?

   3.3 What has the project done to respond to the barriers?
3.4 From your perspective with reference to the IHPB, what issues or barriers to improving the capacity of health services and systems have remained unresolved in the IHPB’s execution of its project? How could these issues and barriers be resolved?

4. As a third line of inquiry, we are being asked to address the following issue:

   How well is the integration of health services approach working in the covered area?

4.1 How would you define integration and its importance to improved HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services at management levels?

4.2 To what extent has the program been effective in integrating HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services at management levels? In what way could collaboration between the health services and management be improved?

4.3 What has been the impact of the IHPB’s emphasis on integration of health programs?

4.4 What steps should be taken in the future to increase effective integration of HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) services at management levels?

5. As a fourth and final line of inquiry, we are being asked to address the following issue:

   What lessons learned can inform project management for the remainder of the project life and future potential follow-on designs?

5.1 Looking back at the IHPB’s first three years of project implementation, what lessons have been learned that will help inform project management for the remainder of the project’s life?

5.2 In the context of the IHPB, how would you define sustainability?

5.3 Based upon your definition of sustainability, what aspects of the project are sustainable? What has contributed to their sustainability?

5.4 Based upon your definition of sustainability, what aspects of the project are not sustainable? Why, in your opinion, are these aspects of the project not sustainable?

5.5 With reference to the IHPB final two years of operation, what actions or interventions would you recommend to build upon and improve prospects for the sustainability of IHPB activities?

5.6 If you were to be involved in the design of a project to continue after the IHPB is completed in September 2018:
5.6.1 What would be your principal goals and objective for such a project?
5.6.2 What parameters (e.g., geographical, focus, technical components, cost, staffing, etc.) would define such a project?
5.6.3 Do you think that the geographic focus of the IHPB project is appropriate? Are there provinces or districts where the project is currently not working but in which it could potentially have a significant positive impact?

(To moderator: The final question is designed to give the key informant an opportunity to address additional points of importance that were not covered during the interview. Care should be taken to encourage the respondent to respond as openly and as frankly as possible in providing this additional input).

6. The purpose of this performance evaluation is to assess progress that the Integrated Health Project Burundi (IHPB) has made to date in achieving its objectives and to document the effectiveness of the project’s approaches and responsiveness to integrating and improving health behaviors, services and systems. The evaluation is also expected to provide recommendations for the design of a possible successor to the IHPB project. In addition to points that we have already discussed, do you have additional observations or recommendations that will assist the evaluation team in responding to the overall evaluation objective?
IHPB Performance Evaluation: Observation Check-List for Health Facilities

Facility Name: Facility Location: Province:District:
Date of Visit:
Name of moderator:
Focus: Increased use of quality integrated health and support services

1. Are records on drug availability up-to-date? _____Yes _____No
   a. If so, is there any evidence of stock-outs? _____Yes _____No
   b. If so, which drugs are currently out of stock-out? (List drugs)

2. Does the site have a list of equipment received from the project? _____Yes _____No
   a. If yes, check the first two items on the list to determine if they are functional.

Add comments on functionality:
Item 1: Description of itemDescription of functionality

Item 2: Description of itemDescription of functionality

3. What modern contraceptive methods are available in the health center? List methods:
   a. Pills _____Yes _____No
   b. Injectables _____Yes _____No
   c. IUDs _____Yes _____No
   d. Female Condoms _____Yes _____No
   e. Male Condoms _____Yes _____No
   f. Laparoscope for Tubal ligations _____Yes _____No
   g. Instruments for a vasectomy tray* _____Yes _____No _____ DK
* Please see list of items typically below that are needed for a vasectomy tray. As this is highly technical, you will need to rely on the technician responsible for vasectomies to confirm that all instruments for a vasectomy are available. If the technician is not available, check DK (i.e. “Don’t know”)

4. Which of the following guidelines are readily available?
   a. Laminated copies of IPTp implementation guide;
   b. Algorithms on IPTp;
   c. Algorithms basic emergency and newborn care (BEmOC);
   d. ART guides;
   e. PMTCT guides;
   f. Case management of malaria;
   g. Post exposure prophylaxis (PEP) guides;
   h. HIV testing and counseling (HTC) standard operating procedures (SOPs).

5. Are records available on IHPB visits for supervision during the 12 months? _____Yes _____No
   a. If so, in what month did the IHPB last visit the health center for supportive supervision for:
      i. Malaria: _____MM _____YEAR
      ii. Child Health: _____MM _____YEAR
      iii. Maternal and Newborn Health: _____MM _____YEAR
      iv. Reproductive Health and Family Planning: _____MM _____YEAR
      v. HIV/AIDS: _____MM _____YEAR
6. Is there a chart for quality improvement (QI) visibly displayed in the health facility?
     _____Yes _____No

* Equipment for a Vasectomy Tray, Mosquito hemostats (3), Adson forceps, Towel clamps (3),
  No. 7 scalpel handle, No. 15 scalpel blade, Needle holder, Iris scissors, Surgical clip applicator,
  Stainless steel surgical clips, Disposable thermal cautery, 4-0 chromic suture, 10-mL syringe with
  27-gauge needle, 1% lidocaine (Xylocaine) without epinephrine, Sterile gauze, Fenestrated
  drape, Sterile gloves
Guiding Questions

1. What do you think about the health care provided for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) by the health center?

   *Instructions to Moderator: You should probe for the client to express both positive and negative aspects of care provided at the health center.*

2. During the past twelve months, what changes, if any, have you observed or experienced in the quality of care provided for these services in your health center?

3. How could these health center services be improved?

4. What do you think about the quality of care provided by the health center within your community for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH)?

   *Instructions to Moderator: Please note that, for this question, the focus is on the services provided by the health center not by the CHW. You should probe for the CHW to express both positive and negative aspects of care provided at their communities.*

5. During the last twelve months, what changes have you observed or experienced in the quality of care provided for these services in your community?

6. How could these community services provided by the health center within the community be improved?

7. Let's discuss your work with your health care work with your community:

   a. What types of care do you provide to your community?

   *Instructions to Moderator: You should allow the CHWs an open discussion on the care they provide to their communities:*

   b. Do members of community appreciate the care you provide? _____ Yes _____No

      i. If no:

         1. Why do they not appreciate the care you provide?

   c. What additional types of care would the community like you to offer?

   d. During the last twelve months, did you receive training to allow you to provide health care to your community? _____Yes _____No

   e. If yes:
i. What type of training did you receive?
ii. Who provided the training?
iii. How did the training benefit you?
iv. What type of additional support would assist you in providing better services?

(To moderator: The final question is designed to give the participants an opportunity to address additional points of importance that were not covered during the interview. Care should be taken to encourage the participants to respond as openly and as frankly as possible in providing this additional input).

8. The purpose of this performance evaluation is to assess progress that the Integrated Health Project Burundi (IHPB) has made to date in achieving its objectives and to document the effectiveness of the project’s approaches and responsiveness to integrating and improving health behaviors, services and systems. The evaluation is also expected to provide recommendations for the design of a possible successor to the IHPB project. In addition to points that we have already discussed, do you have additional observations or recommendations that will assist the evaluation team in responding to the overall evaluation objective?
Integrated Health Project Burundi (IHPB) Performance Evaluation  
August 17 – December 1, 2016

Clients and Beneficiaries  
Focus Group Discussion Guidelines

Guiding Questions

1. What is your opinion about the care provided for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) in your health center?

   **Instructions to Moderator:** You should probe for the client to express both positive and negative aspects of care provided at the health center.

2. How could these health center services be improved?

3. What is your opinion about the care provided for HIV/AIDS, malaria, family planning (FP), and maternal and child health (MCH) in your community/village?

   **Instructions to Moderator:** You should probe for the client to express both positive and negative aspects of care provided at the health center.

4. How could these community/village services be improved?

5. During the last year, what changes, if any, have you observed or experienced in the quality of care provided for these services in your health center?

6. During the last year, what changes have you observed or experienced in the quality of care provided for these services in your community/village?

7. Let’s discuss your last visit to your health center:

   7.1. In addition to providing care or services to respond to the reason for the visit, did the staff offer to provide you with other care or services during this same visit?

   **Instructions to Moderator:** If participants respond above that the staff did offer to provide additional care or services, please ask the following question:

7.2. Did you accept the staff’s offer for additional care or services?

   **Instructions to Moderator:** If any participants respond above that they did accept the staff’s offer, please ask the following question:

7.3. Please describe, from your most recent visit, what additional services were provided during your single visit and how the process was managed.
Instructions to Moderator: If any participants respond above that they did accept the staff’s offer, please ask the following question:

7.4. What were your reasons for declining additional care or services?

(To moderator: The final question is designed to give the participants an opportunity to address additional points of importance that were not covered during the interview. Care should be taken to encourage the participants to respond as openly and as frankly as possible in providing this additional input).

8. The purpose of this performance evaluation is to assess progress that the Integrated Health Project Burundi (IHBP) has made to date in achieving its objectives and to document the effectiveness of the project’s approaches and responsiveness to integrating and improving health behaviors, services and systems. The evaluation is also expected to provide recommendations for the design of a possible successor to the IHBP project. In addition to points that we have already discussed, do you have additional observations or recommendations that will assist the evaluation team in responding to the overall evaluation objective?
Integrated Health Project Burundi (IHPB)  
Performance Evaluation  
August 17 – December 1, 2016  

Mid-Term Evaluation of the Integrated Health Project/Burundi (IHPB)  
CSO Focus Group  
Discussion Guideline

OPENING STATEMENT BY THE MODERATOR:  
As stated in my introduction, one of the IHPB’s important objectives is to support an increase in community service organizations' technical and organizational capacities needed to plan, oversee, manage and deliver integrated and improved services in an effective, efficient and responsive decentralized health system. I would like to ask you a few questions that will assist the evaluation team in understanding the extent to which the IHPB has responded to this objective.

1. What is the major focus of your IHPB grant?

2. What have been IHPB’s major contributions to your ability to respond to the focus of your grant?

3. In working with the IHPB, what challenges have you faced in responding to the major focus of your grant?

4. Since receiving your grant, what major accomplishments in terms of developing your capacity as a civil society organization have you achieved?

5. What additional accomplishments in terms of developing your capacity as a civil society organization would you like to achieve?

6. In September 2018, what will be your organizational strengths that you believe will place you in a position to be a direct recipient of USAID funds?

7. In September 2018, what additional technical assistance will be required to strengthen your capacity to be a direct recipient of USAID funds?

8. Looking back at the time you have worked with the IHPB, what lessons have been learned that will improve the project’s effectiveness in working with civil society organizations during the project’s remaining two years.

(To moderator: The final question is designed to give the participants an opportunity to address additional points of importance that were not covered during the interview. Care should be taken to encourage the participants to respond as openly and as frankly as possible in providing this additional input).

9. The purpose of this performance evaluation is to assess progress that the Integrated Health Project Burundi (IHPB) has made to date in achieving its objectives and to document the effectiveness of the project’s approaches and responsiveness to integrating and improving health behaviors, services and systems. The evaluation is also expected to provide
recommendations for the design of a possible successor to the IHPB project. In addition to points that we have already discussed, do you have additional observations or recommendations that will assist the evaluation team in responding to the overall evaluation objective?
ANNEX D. IHPB MIDTERM PERFORMANCE EVALUATION CONSENT FORM

INFORMED CONSENT STATEMENT

Instructions to Moderator: Read the following to the respondents.

Good day. My name is ___________________, and we are conducting a performance evaluation of USAID/Burundi’s Integrated Health Project/Burundi (IHPB). The overall objective of the evaluation is to assess the IHPB’s progress progressively contributed to integrating and improving health behaviors, services and systems at the project’s supported sites.

You have been selected as a Key Informant to provide information that will establish a knowledge base critical to the evaluation team’s ability to respond to the evaluation’s objective. The information collected will only be used for the above purpose. All the information is strictly confidential.

I would also like to clarify that this interview is entirely voluntary and that you have the right to withdraw from the interview at any point without consequence.

At this time, do you have any questions? (Instructions to Moderator: If required, reference the above background information to respond to questions from the informant). Are you willing to participate in this interview and to allow me to take notes?
Yes 1) Instructions to Moderator: Proceed
No 2) Instructions to Moderator: Thank the KI and STOP HERE
May I begin the discussion now?
Yes1) Instructions to Moderator: Thank the KI and continue with the Key Informant Interview
No2) Instructions to Moderator: Thank the KI and STOP HERE
Start Time: _____:_____
Time of conclusion: _____:_____
**ANNEX E. IHPB PERFORMANCE EVALUATION KEY REFERENCE DOCUMENTS**

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<th>Document Name</th>
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<td><strong>IHPB Contract Documentation</strong></td>
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<td>SECTION C - DESCRIPTION/SPECIFICATIONS/STATEMENT OF WORK</td>
<td></td>
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<tr>
<td>Re: AID-623-C-14-00001 - IHP Burundi - New Indicator Approval</td>
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<td><strong>Project Workplan Documentation</strong></td>
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<tr>
<td>IHPB YEAR 1 WORKPLAN December 23, 2013 - December 22, 2014</td>
<td>Workplan for IHPB Activities for Year 1</td>
<td>3/24/14</td>
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<td>IHPB YEAR 2 WORKPLAN December 23, 2014 - September 30, 2015</td>
<td>Workplan for IHPB Activities for Year 2</td>
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<td>IHPB YEAR 3 WORKPLAN October 1, 2015-September 30, 2016</td>
<td>Workplan for IHPB Activities for Year 3</td>
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<td><strong>Annual and Quarterly Reports</strong></td>
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<td>Quarterly Report - October - December 2015</td>
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<td>Quarterly Report - April - June 2016</td>
<td>Report on Quarterly Activities</td>
<td>29-Jul-16</td>
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<td>Performance Indicator Reference Sheets (PIRS)</td>
<td>Report on IHPB achievements against baseline</td>
<td>Jan-16</td>
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<td>IHPB Proposed revisions to mandatory results or performance indicators</td>
<td>Rationale for IHPB’s proposed changes to original mandatory result or performance indicators:</td>
<td>Feb-15</td>
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<tr>
<td>Re: AID-623-C-14-00001 - IHP Burundi - New Indicator Approval</td>
<td>USAID Contract Officers Email approving new revision to indicators</td>
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<td>Assessment Reports</td>
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<td>Document Date</td>
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<td>-----------------------------------------------------------------------------------</td>
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<tr>
<td>Facility Quality Assessment Report</td>
<td>A comprehensive formative/baseline assessment conducted through a series of six individual surveys with the intent to provide specific information for each of the 12 IHPB-supported districts.</td>
<td>Nov-15</td>
</tr>
<tr>
<td>Gender Assessment Report</td>
<td>An assessment of ways in which gender roles, norms, and inequities affect the health of women, men, and children in the context of IHPB. The report also provides initial recommendations for ways in which the IHPB could integrate gender into project activities to promote gender equality and improve health outcomes.</td>
<td>Jan-15</td>
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<tr>
<td>Service Availability and Readiness Assessment (SARA) Report</td>
<td>Established district-level baseline information on health service delivery in health centers and district hospitals to guide project activities, develop project targets, and provide measures against which progress towards project objectives and outcomes can be measured.</td>
<td>Oct-15</td>
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<tr>
<td>Health Services Qualitative Assessment of a sample of 45 health facilities</td>
<td></td>
<td>Jul-16</td>
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<td>RESULTATS DE L’ENQUETE RAPIDE D’EVALUATION DES CAPACITES, PERFORMANCE ET BESOINS EN RENFORCEMENT DES DISTRICTS SANITAIRES SOUTENUS PAR LE PROJET IHPB</td>
<td>Prepared by IHPB</td>
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<tr>
<td>Community Services Mapping</td>
<td>Identifies what health and social support services and commodities are available to individuals and households, and who provides them, at the community level in the 12 project districts.</td>
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<tr>
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<td>Base des Donnees d'integration Muyinga 12-15 to 6-16</td>
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<td>IHPB Muyinga Service Delivery Report 6-15 to 7-16</td>
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<td>Local Partner Final Transition Report</td>
<td>Report to USAID on Certification of CSOs readiness for graduation</td>
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**IHPB Planning Documents**

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<tr>
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**Government Planning Documents**

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**Burundi Reports and Publications**

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**USAID/Burundi Communication, Reports and Guidelines**

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ANNEX F. PROJECT ORGANIGRAMS

Annex F-A. IHPB Central Office Organigram
Annex F-B. IHPB Branch Office Organigram

Field Office Lead
(50% Management) 
50% Technical) 

IHPB Central Office

M&E
Field Tech Officer
Field Tech Officer
Field Tech Officer
Field Tech Officer

Data Manager
ANNEX G. DISCLOSURE OF ANY CONFLICTS OF INTEREST

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

USAID NON-DISCLOSURE AND CONFLICTS OF INTEREST 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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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.

Signature

Date June 13, 2016

Name William Emmet

Title Consultant
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

Sensitivity: Data; or (e) 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.

ACCETPANCE
The undersigned accepts the terms and conditions of this Agreement.

Signature: [Signature]
Date: June 19, 2016

Name: [Name]
Title: [Title]
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

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.

[Signature]
Date 2/02/108/2016

[Name]  
Title [Logistics Assistant]
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.

Signature

Date

Name

Title

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GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT PROJECT

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:
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ACCEPTANCE
The undersigned accepts the terms and conditions of this Agreement.

[Signature] [Date]

NIYONGERE AUDACE [Title]

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