END-OF-PROJECT EVALUATION
Flexible Family Planning, Reproductive Health and Gender-based Violence Services for Transition Situations ("Flex FP") Project
AA No. 623-A-00-08-00051-00

EVALUATION REPORT
FINAL

Submitted by: LTL Strategies

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ABBREVIATIONS

ABUBEF	*Association Burundaise pour le Bien-être Familial*
AHA	African Humanitarian Action (Ethiopia-based NGO)
ARVs	Anti-retroviral drugs
CA	Cooperative Agreement
CBD	Community-based distribution (of contraceptives); also, CBD agent
CHW	Community health worker
DMPA	Depo medroxyprogesterone acetate (depo-provera)
DRC	Democratic Republic of Congo
DSPS	*Direction des Services des Programmes de Santé*
FGD	Focus group discussion
FP	Family planning
GBV	Gender-based violence
HIM	Healthy Images of Manhood
HIV	Human immunodeficiency virus
IDPs	Internally displaced persons
IMT	Integrated mobile team (for outreach services)
MCH	Maternal and child health
MISP	Minimum initial service package (for emergency situations)
MOH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non-governmental organization
PBF	Performance-based financing

PEP	Post-exposure prophylaxis (following rape or other sexual violence)
PNSR	*Programme National de Santé de la Reproduction*
RH	Reproductive health
SGBV	Sexual and gender-based violence
SOW	Scope of work
USAID/EA	USAID East Africa Regional Health and HIV Office
WHO	World Health Organization

EXECUTIVE SUMMARY

A. BACKGROUND

This report presents the end-of-project evaluation of the regional Flexible Family Planning (FP), Reproductive Health (RH) and Gender-based Violence (GBV) Services for Transition Situations, or "Flex FP", project that was implemented in two provinces of Burundi and in South Kivu Province of the Democratic Republic of Congo (DRC) from October, 2008 to March, 2013. The project was funded at a level of $4 million by the USAID/East Africa Regional Health and HIV Office (USAID/EA), and implemented by Pathfinder International and its sub-contractor, IntraHealth International.

The cooperative agreement (CA) under which the project was awarded was originally for four years. However, implementation was delayed by indecision as to the countries to be targeted and other factors, which meant expenditure of the funding pipeline was slowed as well. For this reason, in September 2012, a no-cost extension was signed between Pathfinder and USAID/EA, extending the project for six months, and enabling it to fully complete its mission. Formal project activity came to a close on March 31, 2013.

The concept of the Flex FP project evolved from a desire on the part of USAID/EA to test approaches, on a regional basis, to delivering urgently needed FP/RH and related services to populations – refugees, internally displaced persons (IDPs), returnees and populations in transit –who have been buffeted by political unrest and social disruption in recent decades in East and Central Africa. USAID felt that such approaches needed to be uniquely responsive and flexible, providing models for responding to different phases of crisis situations, such as emergency preparedness, immediate response, and long-term recovery strategies. USAID/EA also wanted such approaches to provide for meeting the special needs of people, largely women, who are invariably victimized by sexual and gender-based violence (SGBV) in the course of such crises and their aftermath.

B. EVALUATION APPROACH

In February 2013 USAID/EA contracted with LTL Strategies to conduct an end-of-project evaluation to document the project's performance and assess the impact and lessons learned from its activities. A three-person team, consisting of LTL Strategies' Eliot Putnam (US-based) and two staff persons from the USAID/EA office in Nairobi, undertook the evaluation for LTL. Field visits and data gathering by the team in Burundi and the DRC took place in March 2013. This was preceded by a period of document review and development of an evaluation work plan and Interview Guide, and followed by team debriefings with USAID/Burundi and USAID/EA/Nairobi.

In visiting project sites in the Muyinga and Kayanza Provinces of Burundi and Walungu and Miti Health Zones in Eastern DRC, the evaluation team had extensive exposure to several examples of each of the models of FP/RH/GBV services that the Flex FP project had tested, as well as to health facilities that had benefited from project support. A detailed timetable of site visits is included in the report that follows. The team met with national, provincial and district health officials wherever it went, and was often accompanied by them on its field visits, affording excellent opportunities for dialogue about the project and its impact. It also contacted key NGOs and other institutions with which the project has worked to obtain their perspectives. Information was gathered by the team, in the course of its many contacts, through a combination of directed interviews, informal discussions with service providers, and focus group discussions with CBD agents, other outreach workers, and beneficiaries.

C. FINDINGS

Findings of the Flex FP evaluation team are presented in this report within the framework of six Key Evaluation Questions listed by USAID in the evaluation scope of work (SOW):

- What have been the achievements of the project in reaching vulnerable populations with FP/RH/GBV services?
- How has the menu of options tested by Flex FP increased access to services for vulnerable populations, and are these services sustainable?
- What have been the successes and failures in achieving "buy-in" to the project on the part of communities, Ministries of Health, local authorities and NGOs?
- What have been the significant challenges faced by the project? How have they been, or could they be, addressed?
- What have been the costs of different models of FP/RH/GBV service delivery tested by the project?
- What aspects of Flex FP have the potential for replication or scale-up at regional or country levels?

The report answers these questions by assessing the achievement of the Flex FP project's multi-sectoral approach to achieving project objectives, which was centered on eight specifically defined Project Strategies:

Mobile outreach activities, implemented through integrated mobile teams (IMTs), complemented services provided through fixed health facilities. They brought comprehensive primary care services to remote areas where health centers were not readily accessible to refugees, IDPs, and other population groups in transition situations. The evaluation team found the IMT model to be particularly dynamic and appropriate to the needs of populations in transition.

Community-based distribution of FP methods and supplies has been a bulwark of the Flex FP project from the beginning. A significant CBD success

story lay in the fact that, in the DRC, CBD agents who are also trained nurses have, since early in the project, been permitted to administer injectable contraceptives along with condoms and oral contraceptives in the community.

Training of core cadres of service providers was a major contribution of the project to the expansion of FP/RH/GBV services at all levels. A key element was training of clinicians and master trainers in SGBV services at the Seruka Center in Bujumbura. However, the ***24-hour drop-in centers*** to which these cadres were assigned did not attract a significant increase in patients who were victims of SGBV, for reasons including non-availability of proper PEP kits and concerns about security, especially at night. Also, and sadly, there is a stigma attached to women who come forward to report sexual violence, so the tendency is not to do so, especially if the quality of SGBV services in clinics is not of the highest.

The project's focus on ***addressing gender issues*** was highlighted by its implementation of the Healthy Images of Manhood (HIM) model. HIM clearly has made great strides in its limited target areas in raising awareness, especially on the part of men, of the importance of sexual and reproductive health, greater balance in family roles, and the destructive nature of SGBV. It is a model that is more than ready for implementation on a larger scale.

Access to health services was enhanced by the commitment of the Flex FP project to invest in rehabilitation and equipping of selected health facilities. A key to the project's strategy of ***community advocacy and health promotion***, this investment in the condition and appearance of communities' health facilities became a source of considerable pride in the affected populations.

Less successful, in the view of the evaluation team, was the project's strategy of ***early planning for emergency preparedness,*** which seemed to the team to have been overly elaborate, costly and time consuming, without significantly enhancing access to services.

From its meetings with provincial, district and zonal health officials, as well as with NGOs, the team observed a high level of cooperation and commitment to mutually agreed goals. This clearly validated the project's strategy of ***partnering and coordination with Government and international and local NGOs***, notably apparent in the existence of MOUs between the project and various entities. More worrisome was the concern of health officials as to how activities launched under Flex FP could be maintained after its conclusion. In most cases there seemed little chance of that happening without alternative sources of external funding.

Challenges to the project included delays, over which project management had no control, between the time the CA was awarded and when significant project interventions could be initiated. Approving a five-year, rather than a four-year, project could have avoided this. Also, as noted, the low level of patients, largely women, presenting for treatment and counseling as the result of sexual and/or

domestic violence remains a challenge, for reasons of stigma, lack of confidence in the health system, and lack of faith in the legal system. And two challenges face the maximization of CBD services. One is to convince health authorities of the inherent value and safety of permitting CBD agents that are trained nurses to administer injectable contraceptives in the community. The second is to meet the training and support needs that are essential to maintaining a vibrant, responsive cadre of CBD agents in the field.

D. CONCLUSIONS / RECOMMENDATIONS / LESSONS LEARNED

The evaluation team believes that IMTs, HIM, and CBD are the service models tested by the Flex FP project with the greatest potential for expansion and replication. The project team is to be commended for the diligent and visionary work that went into their conception and implementation. They are relatively low cost (representative cost figures are included in the report), have achieved wide acceptance and/or appreciation, and are well appreciated in the public sector. It recommends that these approaches to delivery of services to populations in transition be replicated and scaled up in these and other countries and regions. It even suggests that continuation of the Flex FP project itself, which it feels has, on the whole, been very successful, could provide a continuing laboratory for further testing and analysis of these and other models.

Finally, the report discusses what the team concluded were the important lessons that have been learned from the Flex FP project experience, as well as from the evaluation process. Among others, these have to do with the changing nature of the populations the project was designed to serve, the inherent value of key project innovations, and reflections on the work that remains in combating sexual and gender-based violence.

I. INTRODUCTION

This is the report of the end-of-project evaluation of the Flexible Family Planning (FP), Reproductive Health (RH) and Gender-based Violence (GBV) Services for Transition Situations, or "Flex FP", project. The project was funded by the USAID/East Africa Regional Health and HIV Office under an Associate Cooperative Agreement (CA) Award, #623-A-00-08-0051-00, to Pathfinder International, with IntraHealth serving as sub-contractor. The four-year agreement in the amount of $3,999,257 was signed in September 2008. In September 2012, a no-cost extension signed between Pathfinder and USAID/EA extended the project for six months, until the end of March, 2013, at which time formal project activity ended.

In February 2013 USAID/EA contracted with LTL Strategies, an international business and development consulting firm, to conduct a final evaluation to document the project's performance and assess the impact and lessons learned from its activities. A three-person team, consisting of an independent consultant from the U.S. and two staff persons from the USAID/EA office in Nairobi, undertook the evaluation for LTL. Field visits and data gathering by the team in Burundi and the Democratic Republic of Congo (DRC), the two countries in which the Flex FP project was implemented, took place in March 2013.

This report describes the approach used by the evaluation team in gathering and analyzing information, and the scope of its contacts in the countries in question. It details the team's findings, outlines the team's recommendations for the future, and describes the significant lessons it feels have been learned from the implementation of this small but vital project over the past 4 ½ years.

II. BACKGROUND TO FLEX FP PROJECT

Design of this project grew out of a desire on the part of USAID/EA to test approaches, on a regional basis, to delivering reproductive health and other services to populations emerging from periods of social unrest or conflict, of which there have been many in East and Central Africa. It felt that such approaches needed to be uniquely responsive and flexible, providing models for national response to different phases of crisis situations, such as emergency preparedness, immediate response, and long-term recovery strategies. USAID/EA also wanted such approaches to provide for meeting the special needs of people, largely women, who are invariably victimized by sexual and gender-based violence (SGBV) in the course of such crises and their aftermath.

As noted, in September 2008 Pathfinder International was awarded a four-year CA to design and test models for providing FP/RH/GBV services in crisis and post-crisis situations in the region. Delays in project implementation immediately

ensued, due to uncertainty as to which countries would be involved. Rwanda and Uganda had originally been considered, but did not agree to take part in the project, citing the fact that they were not in a "conflict situation." Burundi agred to take part, as a country emerging from years of political crises, and one with significant populations of both refugees and internally displaced persons (IDPs), as well as victims of SGBV. But it took almost a year until the South Kivu region of the DRC, where such crises are still very real, was confirmed as the second participant in this regional experiment.

Further delays were caused by disagreement over the wording used to describe the project. Both governments objected to its referring to populations "in crisis", and settled instead on designating them as populations in "transition situations". The volatile security situation in South Kivu, which often led to attacks on health centers, also contributed to delays in the launch of full project activity in the DRC, as did the slowness of procuring equipment and materials for clinic rehabilitation in both countries.

Pathfinder was not idle during this period. Its many preparatory activities included:

- Conduct of situational analyses of FP/RH/GBV services in Muyinga and Kayanza Provinces of Burundi, and selection of sites in these provinces for testing approaches to delivery of FP/RH/GBV services. (The two provinces were selected due to their already being served by a separate Pathfinder-funded MCH program.)
- Conduct of a feasibility study on community-based delivery (CBD) of injectable contraceptives in Burundi, hoping it would mirror a decision taken by the DRC to permit such services to be provided by CBD agents who are also trained nurses.
- Development of memorandums of understanding (MOUs) and action plans with target provinces in Burundi and Walungu Health Zone in the DRC where the Flex FP project would be active. MOUs were also signed with partner NGOs such as ABUBEF (for jointly fielding IMTs) and AHA (for promoting the Healthy Images of Manhood, or HIM, model in Gasorwe commune and refugee camp) in Burundi.

Nonetheless, despite Pathfinder's best efforts the delays described led to significant under-expenditure of funds in the project pipeline during its early stages. The first trainings of nurses in delivery of FP/RH/GBV services, as well as of HIM trainers, did not take place until the spring of 2010. Launching of integrated mobile health teams (IMTs); purchase and distribution of clinic equipment; and rehabilitation of selected clinic facilities, including installation of solar panels for electricity, all occurred more slowly than anticipated. Indeed, due to the uncertain security situation in the DRC, rehabilitation of two health centers there was only completed in August of 2012. All of this led to the decision by USAID/EA in September of 2012 to grant the project an unfunded six-month extension. This was a sound and reasonable decision, in the eyes of the

evaluation team, one that assured the project of the time required to utilize all authorized funds in completing its mission.

NOTE: It is important to make clear that, while several of the models tested under this project were designed to deliver FP, RH and GBV services, Flex FP was not intended to be a "service delivery" project per se. Rather it was intended as a laboratory to, in the words of the original project document, "identify and develop flexible approaches that can be packaged and mixed and matched into models to deliver services to communities in different phases of crises." Individual models tested were of a size and scope too small to achieve significant statistical results in terms of services delivered. While the evaluation team did gather quantitative data of interest, it was cognizant of the fact that service statistics alone would not be the true measure of the project's value.

III. EVALUATION METHODOLOGY AND TIMETABLE

Once the contract for this evaluation had been awarded by USAID/EA to LTL, the evaluation team undertook a desk review of project-related documents. These included quarterly project reports, an internal mid-term review of the project by Pathfinder, needs assessments, and the aforementioned feasibility study on community-based provision of DMPA. They also included a recent report by IntraHealth on the HIM experience, and two reports, on sexual violence in Burundi and services available for its victims, that were commissioned by the USAID Mission in Burundi. A list of documents reviewed by the evaluation team appears in the Annex to this report.

The team developed a Work Plan for the field portion of the evaluation and an Interview Guide for use in structuring its interactions with project personnel, other stakeholders, service providers, project beneficiaries and others. Questions contained in the Interview Guide (included as **Annex** 1) were keyed to the Key Evaluation Questions specified by USAID in the Flex FP evaluation scope of work (SOW), for which see Section IV below.

Data collection was accomplished through site visits and interviews at many levels, and took place during the weeks of March 18 and 25, 2013. The detailed evaluation timetable can be found in **Annex 4**.

Following completion of the data-gathering portion of the evaluation, the team disbanded and reconvened on April 2 at USAID/Nairobi to brief the Mission on its findings and conclusions. The LTL Strategies consultant then returned to the U.S. to draft the evaluation report.

IV. FINDINGS

Structure of this section:

Findings of the Flex FP evaluation team are presented within the framework of the Key Evaluation Questions listed by USAID in the evaluation SOW, as follows:

- What have been the achievements of the project in reaching vulnerable populations with FP/RH/GBV services?
- How has the menu of options tested by Flex FP increased access to services for vulnerable populations, and are these services sustainable?
- What have been the successes and failures in achieving "buy-in" to the project on the part of communities, Ministries of Health, local authorities and NGOs?
- What have been the significant challenges faced by the project? How have they been, or could they be, addressed?
- What have been the costs of different models of FP/RH/GBV service delivery tested by the project?
- What aspects of Flex FP have the potential for replication or scale-up at regional or country levels?

The report addresses each question in the context of ***eight project strategies*** that made up the multi-sectoral approach the Flex FP project and its implementers, Pathfinder and IntraHealth, used in testing models for the delivery of FP, RH and GBV services to populations in different phases of transition. These strategies, a mix of specific project interventions and broader coordinative approaches, were implemented at different stages of the project depending on circumstances and overall readiness. They are contained in the following box:

1. *Early planning for emergency preparedness, notably contingency planning to ensure access to Minimum Initial Service Package (MISP) of treatments (post-exposure prophylaxis [PEP] kits, emergency contraception, etc.) for victims of sexual violence*
2. *Partnering/coordination with Government and international and local NGOs*
3. *Training of core cadres of service providers at several levels*
4. *Community-based distribution of FP methods, including DMPA*
5. *24-hour drop-in centers and post-rape care*
6. *Addressing gender issues, especially through the HIM initiative*
7. *Mobile outreach activities*
8. *Community advocacy and health promotion*

Each of these strategies is addressed and assessed *(and referenced in italics)* in the findings presented in the following pages, most from more than one perspective. Again, findings are structured around USAID/EA's Key Evaluation Questions listed above. Concluding sections containing Recommendations and addressing Lessons Learned are drawn from these findings.

1. Achievements in reaching vulnerable populations with FP/RH/GBV services

Integrated mobile health teams (IMTs). *Mobile outreach activities* were initiated through establishment of IMTs in Muyinga and Kayanza Provinces in Burundi in early 2011, a bit later in Walungu Health Zone in the DRC. Five such teams were active over the life of the project. The IMTs quickly established themselves as essential complements to services provided through fixed health facilities, bringing services on a semi-regular basis to remote areas where health centers were not readily accessible to refugees, IDPs, and other population groups in transition situations. 50 IMT outreach sessions were held over the life of the project, against a target indicator of 40.

IMTs were joint ventures of the Flex FP project and local partners. For example, in Burundi's Muyinga Province, the IMT was fielded under an MOU between Pathfinder and ABUBEF, the leading family planning NGO in Burundi. On the day of the evaluation team's visit to the IMT site in Nyungu District, ABUBEF provided the vehicle to transport workers and materials to the site, as well as FP service personnel. At other times, a local government vehicle might be used. Also participating were clinical staff from the Nyungu health center, health workers seconded from the Pathfinder-supported MCH program, and volunteers and CBD agents from the community. A full team assembled for an IMT session numbered 15-16 workers.

Frequently IMT visits coincide with a local market day, to ensure maximum access for members of the community. Services are offered from early morning through the afternoon, to allow for people to plan their visits to the clinic site around their work tending crops in the fields. Integrated services offered by IMTs include:

- Confidential FP counseling and a full range of methods (condoms, pills, injectables and implants) as well as referrals for permanent methods
- HIV counseling and testing
- Education on nutrition and meal preparation for infants and children; growth monitoring promotion; screening for acute malnutrition
- Ante-natal counseling and child health care
- Home-based management of malaria
- Immunizations for mothers and children
- Confidential GBV services and counseling.
- In some cases a physician is also on scene for patient consultations.

The evaluation team witnessed several IMTs in action. It was impressed by the range of services offered and the obvious enthusiasm for them on the part of community members, many of whom would be far less likely to travel to a distant health center. The concept and rationale for mobile health teams is not a new one, but the popularity and comprehensiveness of this model, and its relatively low cost (the Flex FP project office estimated that fuel, travel time and supplies for a typical, day-long IMT session averaged $480) made it especially appealing. Equally impressive was the fact that IMTs are joint efforts, engaging local health authorities and service providers, NGOs, volunteers and CBDs, a factor in favor of the model being sustained.

A notable IMT success story can be found in Kayanza Province. The evaluation team visited a busy Saturday/market day session of an IMT in the *colline* of Rugogwe. At first supported by Flex FP, this IMT is now fully financed by the District Health Office under the performance-based financing (PBF) program underwritten by the World Bank. But it also pointed out the fact that maintaining regular services of other IMTs is by no means assured, now that Flex FP is over.

CBD outreach. The *community-based distribution* of contraceptive information and supplies has been a bulwark of the Flex FP project from the beginning. As in many countries, CBD agents constitute the most basic point of contact between the community and the health system, a fact especially true for populations in transition, in places such as IDP camps, for whom dependable health care can be elusive. Over 800 CBD agents were trained and/or retrained by the project, and equipped with appropriate information and contraceptive supplies – pills, condoms, cycle beads, and (in the DRC), injectables. CBD agents are so essential to Burundi's health system that the Government has determined their

numbers will be increased from two for each *colline* to one for each *sous-colline.*[1]

The most significant CBD success story, thanks in part to vigorous advocacy on the part of the Flex FP project, lay in the decision, first by South Kivu RH authorities and then by the central DRC government, to permit DRC nurses designated as CBD agents to provide injectable contraceptives in the community, without requiring a clinic visit. Since the summer of 2010, over 100 such CBD agents were trained to provide DMPA in the community, and over 4,100 injections have been administered, against a target of 2,800. On the other hand, despite preparation of a detailed feasibility study on the advantages of community-based provision of injectables, Flex FP was unable to prompt a similar decision from the Burundian MOH, which rejected what it called the "de-medicalization" of injectables. The most popular contraceptive method must still be administered in a health facility.

Training. The *training of core cadres* of service providers was a major contribution of the project to the expansion of FP/RH/GBV services at all levels. Training and refresher training of CBD agents, FP training for clinical service providers, and "sensitization" and training of HIM champions (Burundi) and peer educators (DRC), were an integral part of project inputs beginning in 2010.

A significant component of the project's overall training strategy was its contract with the Seruka National Referral and Training Center in Bujumbura to train clinicians in SGBV service provision. During the 2011-2012 period, 24 nurses, selected by the Burundian MOH, participated in intensive one-week training courses at the Seruka Center in the treatment and counseling of SGBV victims, followed by a 10-day supervised practicum. In late 2012, 5 of the most skilled of these service providers received an additional 5 days of training as SGBV master trainers. At about the same time, similar training, of both care givers and master trainers from Walungu and Miti Health Zones, took place in the DRC under the aegis of the South Kivu Department of Reproductive Health.

One of the objectives of the specialized SGBV training was to enable health facilities staffed by newly trained providers to serve as *24-hour drop-in centers* for victims of sexual violence. 17 such centers were established, and these facilities may yet develop into fully functioning drop-in centers[2], but certain factors have muted that result to date. (1) Many facilities are not fully equipped with the latest post-exposure prophylaxis (PEP) kits, i.e., those that contain three antiretroviral drugs (ARVs), which is now the WHO standard, rather than the previous two. (Some may lack PEP kits altogether.) (2) All nurses have not yet

[1] *Colline*, for "hill", and *sous-colline*, for "small hill", are the most basic administrative units in mountainous Burundi. Each *colline* is made up of several *sous-collines.*

[2] All health facilities in the Burundian health system are normally open 24 hours per day, or staff can be quickly summoned from their nearby homes. The "drop-in" facilities in question, supported by the project, were staffed by nurses trained at Seruka specifically to treat and counsel sexual assault victims.

been fully trained to initiate ARVs with patients suspected of being infected with HIV. Those without such training must refer patients to a doctor at the hospital for initiation, which can present daunting logistical problems for the patient. (3) There is an issue of security, especially at night, when patients may be unwilling to go to the clinic no matter how dire their circumstance.

Healthy Images of Manhood (HIM). The importance of *addressing gender issues* has been highlighted with considerable success with the introduction in pilot areas of the HIM model for raising awareness, especially on the part of men, of the importance of sexual and reproductive health, and of the destructive nature of SGBV. The rationale for the HIM approach, based on a model first used in Tanzania, is put forth in an excellent recent paper, "Healthy Images of Manhood", by IntraHealth, the partner responsible for this aspect of the Flex FP project. The HIM model was piloted in the Gasorwe Commune and Refugee Camp in Muyinga Province of Burundi, and in the Walungu and Miti Health Zones of the DRC. A HIM training manual was developed, and used to train HIM champions/peer educators in the two countries.

In visits to these sites, the evaluation team was struck by the vehemence with which many men, having had HIM "sensitization" and/or training as champions or peer educators, expressed their determination to change their behaviors by showing greater respect for their wives and shouldering more of the household burdens. In a training exercise that had particular impact, men and women were asked to separately list the different duties for which they are responsible on a normal day. The women's list (preparing meals, child care, housework, washing clothes, tending the fields, going to market, carrying water, tending to animals) invariably proved to be far longer than the men's. One particularly energized man who had participated in the exercise confessed, "we are not doing anything!" He and many like him are vowing to do more, to share burdens, and to break out of traditional habits and ways of thinking.

A second observation of the team was the extent to which testimonies of men who had embraced the HIM concept invariably circled back to the importance and desirability of contraception for birth spacing. This is especially impressive in light of the Situation Analysis conducted in Burundi by the Flex FP project in January 2010 (see Bibliography, **Annex 3**.) In referring to the Gasorwe Commune and Refugee Camp, the analysis observed that, at the time, *Un comportement pro-nataliste est perceptible chez les populations du site de Gasorwe.* ("A distinctly pro-natalist attitude is observed among residents of Gasorwe.") The HIM model has clearly made inroads into that attitude.

The HIM model as implemented by Flex FP was small in scope. But the positive responses it engendered in sites where it

was tested speak well for testing it on a much broader scale. They also highlight its potential not only to begin to lessen the proclivity toward sexual and gender-based violence but to promote family planning in the process.

A dynamic success story. *In the 2010 Situation Analysis referenced above, mention was made of the Nyarurama District in Kayanza Province of Burundi, where, selon nos interlocuteurs, la pratique contraceptive leur est pratiquement inconnue. ("According to our contacts, contraception is practically unknown.") At the time of the evaluation team's visit to Nyarurama, where the project had made significant investment in outreach, training and clinic rehabilitation, it found a very different state of affairs. Health center statistics indicated a high level of acceptance of contraceptive methods, with DMPA the preferred option, followed by implants. More striking still were the team's FGDs with CBD agents and beneficiaries. All were anxious to talk about their desire to space births and their contraceptive methods of choice. The Pathfinder Team Leader spoke proudly of Nyarurama's progress as one of the project's most impressive achievements*.

2. Has the Flex FP menu of options increased access to services to vulnerable populations, and are these services sustainable?

Integrated mobile health teams. There is no question that the Flex FP project's support for *mobile outreach activities* through IMTs has significantly increased access to integrated FP/RH/GBV services for populations in transition. Even as IDPs, refugees and others become gradually more settled in their present locations, where they have been, in some cases, for several years, their camps and settlements may be far from fixed health facilities, with limited access to transport, and IMTs fill a pressing need for primary health services.

Whether they are sustainable is another matter. The average cost to the Flex FP project of a full day IMT session was $480, not a high price considering the range of services offered but one that nonetheless may be hard to meet. For example, the Chief Medical Officer of the Miti Health Zone in the DRC told the evaluation team that the ending of the Flex FP project and its support for outreach services would mean a sharp reduction, or even cancellation, of such services because of the high cost of fuel. He will try to find alternate sources of external funding, but this is by no means assured.

In some cases in Burundi, Kayanza Province being an example, costs of maintaining IMTs and other service activities have been absorbed by provincial

health structures through the World Bank-financed PBF program. Provincial and District health systems are reimbursed by the MOH for every contraceptive acceptor or consumer of other services, according to a strict, and carefully monitored, formula. Records are regularly reviewed by a team of MOH and Pathfinder inspectors to verify service statistics before reimbursements are approved. The system is rewarding for high performing facilities and programs, such as in Kayanza. On the other hand, those that perform less well either do not qualify or fail to generate significant reimbursements.

CBD outreach. The emphasis on *community-based distribution* of contraceptive information and products, through *training of core cadres* of CBD agents and their logistical support, has added substantial value in providing access to services for populations in transition. This is especially true in the DRC, where trained nurses serving as CBD agents have been administering injectable contraceptives in the community for almost three years. DMPA is the preferred contraceptive for a majority of women in the region. Increased access to injections without requiring a clinic visit has significantly increased numbers of acceptors. It is hoped that efforts to convince the Burundian MOH of the value of this intervention will eventually bear fruit.

Rehabilitation of health facilities. Access to services was also enhanced by investment of the Flex FP project in rehabilitation of selected health facilities in project areas. Six such facilities, small hospitals and referral health centers, were renovated, repaired, painted, and/or otherwise brought up to standard by Pathfinder, at an average cost of $39,000 per facility. It can certainly be said that the project strategy of *community advocacy and health promotion* was enhanced by this investment in the condition and appearance of communities' health facilities, in which community members took unabashed pride.

Rehabilitation included the installation of solar panels to provide health facilities with dependable electricity. Under a separate budget category, the project also equipped most of the health facilities covered by the project with basic equipment such as new beds, delivery and examination tables, sterilizers, and plastic rain-collection barrels.

The risks and insecurity of implementing services in the region covered by the Flex FP project were brought home when, mid-way through the project, a referral health center in Walungu Health Zone in the DRC that had been rehabbed by the project was destroyed in the course of rebel military action. The facility was subsequently rebuilt with project assistance.

Services for victims of SGBV. One of the service models tested by the Flex FP project was the introduction of the concept of *24-hour drop-in centers* for treatment and counseling of victims of sexual violence, with clinics staffed by nurses trained for the purpose. This has probably marginally increased access to such services, but records are incomplete, and, as described above, certain factors have so far prevented optimal utilization. One is that PEP kits at health

facilities may be lacking or not up to current standards. A second is that, while the MOH now allows nurses to prescribe ARVs, appropriate training has not yet been rolled out in all areas, meaning that women potentially infected with HIV may still be referred to a doctor at the hospital to initiate ARVs, with health centers only stocking ARVs to resupply HIV+ patients. Late night security is also an issue.

Contingency planning. The strategy of *early planning for emergency preparedness* seemed to the evaluation team to have been overly elaborate and time consuming, without significantly ensuring access to services. Substantial time and expense was devoted to developing and publishing detailed *"Plans de Contingences"*, both national and specific to Muyinga and Kayanza Provinces. These contained elaborate scenarios and lists of responsible agencies for dealing with any sort of emergency, from fires to road accidents to natural disasters, as well as outbreaks of violence and civil unrest.

Largely lost in the detail were the key items dealing with health issues resulting from conflict and its inevitable sexual violence. These involve making certain that the "minimum initial service package", or MISP, for victims of SGBV, containing PEP kits and emergency contraceptive methods, is readily available and in competent hands. In future, the team feels that such contingency planning should be limited to ensuring that the MISP is in plentiful stock or immediately accessible for any eventuality, and that health service providers are appropriately trained in its utilization. This would put the focus directly on patients, and their specific emergency needs, that the Flex FP project was designed to support.

Contraceptive supply. Access to services was also enhanced, at least in Burundi, by a strong contraceptive logistics system, an important contributor to this project's success. Indeed, Burundi has not recorded stock-outs of contraceptive commodities in many years.

3. What have been the successes and failures in achieving "buy-in" to the project on the part of communities, Ministries of Health, local authorities and NGOs?

Overall. From its visits and observations, the evaluation team felt that the strategy of *partnering and coordination with Government and international and local NGOs* has been achieved. Mention has been made of the MOUs or contracts signed between the project and various entities:

- ABUBEF, in support of IMT activities
- AHA, in support of HIM promotion in Gasorwe Commune and Refugee Camp
- The Seruka Center for training in SGBV services and counseling
- Local health authorities in Health Zones (DRC) and Provinces (Burundi), for implementation of agreed work plans.

From its meetings with provincial, district and zonal health officials the team observed a high level of cooperation and commitment to mutually agreed goals. The success of Kayanza Province in Burundi in having innovations launched by the Flex FP project, such as IMTs, absorbed under the PBF program was testimony to strong collaboration and mutual growth. Equally eloquent, but in a more worrisome way, was the concern expressed by health officials wondering how activities launched under Flex FP could be maintained after its conclusion. In most cases it appeared as if there would be little chance of that happening without alternative sources of external funding.

CBD. The one striking contrast in terms of government "buy-in" to the project's approaches was the fact that the Government of the DRC early on approved the community-based administration of injectable contraceptives in the community by CBD agents who are trained nurses, while the Burundian Government has not. The result has been substantial levels of request for DMPA in the DRC, well above targets.

SGBV services. In its concentration on *addressing gender issues*, the Flex FP project invested substantial time and resources in creating awareness and strengthening services related to SGBV. The HIM model, training in SGBV treatment and counseling, the establishment of *24-hour drop-in centers*, all were evidence of this focus.

The level of "buy-in" at different levels seems to vary. Certainly an institution such as the Seruka Center understands that sexual and gender-based violence, including domestic violence, are enormously serious issues requiring continued, intense attention. At senior government levels, as well, there seems a willingness to discuss and a serious commitment to dealing with these issues, resources permitting.

At provincial and district levels, the level of commitment is harder to quantify. The evaluation team felt that, in its interviews and FGDs, people tended to downplay the issues. Sadly, there is a stigma attached to women who come forward to report domestic violence, so the tendency is not to do so. When women are brave enough to come forward, they may be sent to have ARVs initiated by doctors in the hospital because nurses in the health center have not been properly trained. Changes in practices and policies, and especially in attitudes, come slowly. Efforts to bring them about must be unrelenting.

4. What have been the significant challenges faced by the project? How have they been, or could they be, addressed?

Delays in implementation. Mention was made earlier of significant delays that occurred, over which Flex FP project management had no control, between the time the CA was awarded and significant project interventions could be initiated. These included indecision on countries to be targeted, and the insecurity situation in the DRC. Testing of models of service delivery for populations in

transition did not in fact begin until well into Flex FP's second year, and most service activities took place during the second half of the four year project.

Delays in implementing projects are not unusual, especially when dealing with an experimental project design with a regional focus, i.e., one requiring approvals and development of work plans in more than one country. In this case, although project activities were indeed held up, the full project budget was ultimately utilized as intended, thanks to the decision to grant the project a six-month unfunded extension. But in retrospect, given its complexities, USAID/EA might have been well advised at the outset to approve a five-year project, rather than one with a duration of only four years.

Treatment of SGBV victims. The low level of patients, largely women, presenting for treatment and counseling as the result of sexual and/or domestic violence will remain a challenge well into the future. Training a limited number of service providers and master trainers at the Seruka Center, and establishing *24-hour drop-in centers* for victims, were important first steps in meeting this challenge, and in helping to raise the profile of the issues, but much more is needed.

The goal now must be to strengthen available services through (1) expanded training of service providers; (2) ensuring routine availability of standardized PEP kits at health centers; and (3) reinforcement of policies that permit trained nurses at the health center to initiate ARV treatment for HIV+ patients. Too often patients are referred to doctors at the hospital for such initiation, with obvious negative implications in terms of transportation costs and time lost.

Equally important will be more accessible, informed counseling of victims as to their options in seeking legal redress for their suffering. Realization of these goals could hopefully establish a climate that is more "user friendly", one that would convince more women to come forward.

But this will be a slow process, and this report has touched on some of the reasons as they have surfaced in the course of this project. For an excellent, expanded description of the cultural, technical and policy-related obstacles to greater and more accessible utilization of SGBV treatment and counseling, readers are referred to the October 2012 report by the Respond Project on "Services for Sexual Violence Survivors in Kayanza and Muyinga Provinces, Burundi."

CBD. Two challenges face the maximization of *community-based distribution* of contraceptive services. Utilization of nurses in the DRC to provide injectable contraceptives in the community grew from the availability of unemployed trained nurses who could fill this role. Many were subsequently employed by the MOH and now provide both CBD and clinic-based services. This gives rise to the suggestion that Burundi and other countries could seek out trained but

unemployed nurses, clinical officers and others who are available in the community and could be trained as CBDs to provide injectables.

These countries would also need to pursue a parallel track to overcome policy obstacles to such utilization of these cadres. Despite rigorous effort, Flex FP was unsuccessful in obtaining policy changes in this regard from the Burundian MOH. But success in the DRC for almost three years demonstrates that this can be a sure-fire way to increase rates of acceptance of the most popular of contraceptive methods.

The second challenge is to meet the training and support needs that are essential to maintaining a vibrant, responsive cadre of CBD agents in the field. The Government of Burundi has authorized an increase in the size of that cadre, but it is not clear that it has also assured the means of their support. What that support should entail deserves continual review. Many CBD agents with whom the evaluation team spoke were outspoken in expressing their need for some sort of *motivation*, i.e., modest financial compensation, for all that they do in their communities. This is of course a familiar issue wherever community health workers (CHW) are an integral part of national health systems, and the core question is one of affordability. Nonetheless, there is a need for new ideas as to how to reinforce motivation and effectiveness of this key cadre of health worker.

5. What have been the costs of different models of FP/RH/GBV service delivery tested by the project?

Representative costs for key Flex FP project innovations are listed, based on figures provided in project documents and the project office in Bujumbura.

- **Integrated mobile teams.** Overall cost to the project of implementing the IMT model was slightly more than $24,000. For the approximately 50 IMT outreach sessions conducted in Burundi and the DRC the average per-session cost came to $480. This covered fuel and other transportation costs, food for demonstration nutrition activity, and other small equipment or supply expenses. Time of health center staff and other public sector participants was contributed by governments.
- **The HIM model.** Training of approximately 700 HIM champions in Burundi and another 100 HIM peer educators in the DRC came to $61,000. This works out to about $76 per trainee, quite reasonable when one considers that most individuals trained as HIM promoters remained in their communities to continue their promotional work.
- **CBDs.** The cost of training roughly 1,100 CBD agents in Burundi and the DRC, including nurse CBDs in the DRC, came to $210,000, or about $200/trainee, which covered travel costs and per diem during training and starter kits of contraceptive supplies, bags, shirts, and bicycles.
- **Other training.** The costs of training 24 nurses, and subsequently 5 master trainers, in SGBV treatment and counseling at the Seruka Center in Bujumbura came to just over $15,000, or roughly $525 per trainee.

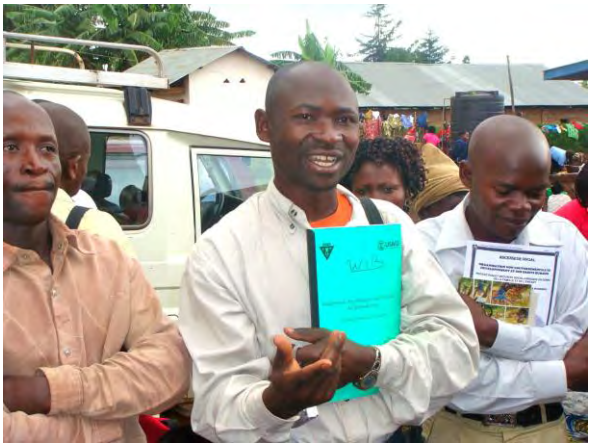
- **Renovations.** The project spent $234,000 on renovations to 6 selected health facilities in Burundi and the DRC, for an average of $39,000 per facility. This included installation of solar panels to provide electricity for health center lighting. Contributions of equipment for most health facilities involved in the project, such as examination and delivery tables, sterilizers and other clinical equipment, and plastic rain collection barrels, were covered under a separate budget line item.

The evaluation team was not able to make comparisons of these costs with similar costs for other projects. This was in part a function of time pressures, and in part because of the unique nature of Flex FP. However, based on team members' experience over time with projects offering similar services, it feels that these costs are low to moderate, and in any case quite reasonable, especially as regards IMTs, HIM, and CBD training. It felt that costs of training offered by the Seruka Center were extremely reasonable.

6. What aspects of Flex FP have the potential for replication or scale-up at regional or country levels?

The evaluation team feels that, among the models for providing FP/RH/GBV services to underserved populations in transition situations that have been tested by the Flex FP project, three have the most potential for replication and scale-up.

Integrated mobile teams. The team found that the particular format and approach to *mobile community outreach* represented by the Flex FP project's IMTs has great potential for expansion and replication wherever underserved populations, whether in transition or simply neglected, are found. The integrated nature of the model, that provides a full range of primary health services at a pace and in settings that recognize the realities of peoples' lives and situations, and makes the most of local resources, service providers and volunteers, is well suited to such situations.



Healthy Images of Manhood. The HIM model was tested in quite limited settings in Burundi and the DRC, but the enthusiasm and acceptance that it clearly generated convinced the team that it is a model for *addressing gender issues* that should be taken to scale. Especially if accompanied with carefully developed publicity, it shows great promise as a strategy for developing a movement to increase awareness of the pain and terror of SGBV, engaging men to become more co-equal partners with their wives in shouldering family burdens, and

making them active promoters of contraception for the purpose of spacing births. (Convincing men *and* women to embrace the concept of small families is a long shot, but if people determine that having 5-6 children makes more sense than having 8-9, progress will have been made!)

CBD. Community-based distribution of contraceptive services is not a new model, but the Flex FP project has once again proved its importance and its viability. The project's approach to CBD training and follow-up has produced impressive results in terms of methods distributed in target provinces and health zones. Given its importance to rural health outreach in many countries (CBDs are trained not only to inform on and distribute contraceptives, but also refer people to the nearest health facility for other health issues), the model needs constant analysis to determine ways that it can be strengthened.

V. CONCLUSIONS AND RECOMMENDATIONS

- The evaluation team clearly felt that three models tested by the Flex FP project, ***Integrated Mobile Teams, Healthy Images of Manhood,*** and ***Community-based distribution*** of contraceptive information and methods, have been widely appreciated and accepted and should be replicated and scaled up in these and/or other countries or regions. Pathfinder and its partner, IntraHealth, deserve great credit for implementing these models so carefully and successfully.

- With specific regard to CBD, strengthening the model should continue to be a priority, as should every effort for the (very reasonable) costs of fielding CBD agents to be covered under Ministry of Health budgets. This is especially true when, as in Burundi, government policy is specifically increasing authorized numbers of these community health workers. Where that is not yet possible, financing schemes along the lines of the performance-based financing approach are the next best thing.

- Contingency planning has its place, especially in areas and circumstances of potential conflict or unrest. But such planning should be simplified and limited to a specific area of interest. In this case that would be assuring that the MISP for victims of SGBV is immediately accessible, in sufficient quantities, for any emergency, and that health service providers are appropriately trained in its utilization.

- SGBV remains a sensitive issue. Focused attention must be paid to increasing awareness of its often tragic results, and to continually improving access to and quality of services for those affected. One specific measure in this regard would be to ensure the capacity of trained nurses at the health center level to initiate ARVs for HIV+ women, and to eliminate any policy obstacles to such services, real or imagined. A second would be to give service providers and counselors more training in helping victims of violence to seek legal redress for damage done them.

- Even when health providers are fully trained to offer GBV services, and selected facilities offer 24 hour services, PEP kits may not be available. Where they are, they often contain two, instead of the recommended three, ARVs. This is a situation that must be rectified and standardized.

- Flex FP was intended by USAID/EA as a pilot project, to test particular innovations on a small scale over a finite period of time, and to determine which models would be appropriate for replication and scale-up in these or other regions or countries. Since it did not seem to be expected, the evaluation team has stopped short of recommending a second Flex FP phase along the same lines and in the same locations. If, however, the project were approved for a second phase, even while the models it tested are also being implemented elsewhere, it could continue to be a laboratory for approaches to serving populations in transition. It could take the HIM model to more varied population groups. It could work towards greater sharing of roles and costs of IMTs with local entities, and to transitioning key activities to the government or other partners. In Burundi, it could potentially achieve approval for trained nurse CBD agents to deliver injectable contraceptives in the community. It could make 24-hour drop-in centers a fully viable concept. In short, a second phase of Flex FP could expand substantially on progress achieved in the first.

VI. LESSONS LEARNED

- It was apparent to the evaluation team that the nature of IDPs, refugees and other population groups in transition served by the Flex FP project is changing, and has done so over the life of the project. Situations are fluid, and there will always be some movement of residents of these communities, whether back to their original homes or somewhere else. But in the absence of disruptive events they are tending more and more to stay where they are, where they have rebuilt their lives. This calls for ensuring access to services more like those provided to more settled, non-transient communities, rather than populations at risk and on the move.

- In settings where access to basic health services is limited, there is no substitute for bringing mobile, integrated services to the people where they live and work. It is also important to do it on a regular, dependable basis, and in a way that allows members of a community to obtain all primary care services required, and have all questions answered, on a confidential basis when necessary. The Flex FP project IMT model did this with its day-long sessions in remote locations, and did so at reasonable cost. Where IMT visits cannot be maintained following conclusion of the project, they will be greatly missed, and community health may suffer.

- Operationally speaking, trying to rush a project into operation without being fully prepared can lead to frustration, delays, and under-expenditure of its pipeline, at least in its early stages. This is especially true of a project such as Flex FP, which, while relatively small (total budget of $4 million), was breaking new ground in terms of services and target populations, and doing it in more than one country and in a variety of settings.

- It is also important to note that insecurity, especially in the DRC, was a major contributor to delays in project implementation. In some instances, notably where health facilities were badly damaged, services were significantly disrupted.

- A strong, dependable contraceptive logistics system in Burundi contributed to the success of the Flex FP project. Burundi has not recorded stock-outs of contraceptive commodities in many years.

- HIM works, at least on a “micro” level. It is simple. It is low cost. And the champions and peer educators trained as its ambassadors are of the community, so their knowledge and motivation will remain a constant.

- Combating sexual and gender-based violence is a long, slow process. HIM and models like it, if vigorously pursued, will help raise awareness. Training and retraining of nursing staffs, and ensuring availability of supplies and comprehensive services at health centers, should gradually increase utilization. But the efforts of policy makers, NGOs, service providers and the community must be unrelenting in creating a climate where SGBV is no longer tolerated in any form, and the stigma of making it public is erased.

ANNEX I

FLEX FP END-OF-PROJECT EVALUATION

Interview Guide

Methodology Note

Interview questions, and the way they are posed, will be adapted to suit interlocutors or groups of interlocutors with varying levels of literacy, using the *participatory data collection methodology*. For example, if dealing with a rural association, versus an urban NGO, instead of using the interview technique with the questionnaire in hand, the evaluator will use a more conversation-based technique (either through focus groups or informal group chats).

In such cases, the overall assessment of project achievements, shortcomings, and impact will be addressed by focusing on the *who, what, when, where, how*, and *why* questioning technique.

LTL Strategies is sensitive to the need to remain flexible in the use of data collection methods, given that Flex FP has been implemented and managed in both urban and rural settings, and in a conflict-prone region.

The following interview guide, therefore, is a sample, and will be dynamized and adjusted to suit the various situations we may encounter on the ground.

Participatory Data Collection

Participatory data collection is generally associated with qualitative methods of information gathering. Qualitative methods, in comparison to quantitative methods, tend to be more concerned with words than numbers. Qualitative methods are therefore based on data collection and analysis of that data. The focus is on interpreting the meaning of social phenomena based on the views of the participants of a particular social reality. (e.g., health training and product recipients in a rural, conflict-prone, or post conflict reconstruction setting).

Participatory approaches contain a variety of data collection methods: (a) participatory listening and observation; (b) visual tools such as maps, daily activity diagrams, institutional diagrams and Venn diagrams, flow diagrams and livelihood analysis; (c) semi-structured interviews; and (d) focus group discussions. Among the participatory methods of evaluation, semi-structured interviews and focus groups are the most often used instruments for gathering the views of participants on certain topics and issues, particularly with interlocutors who are either illiterate or have relatively low levels of literacy. Participatory listening and observation, using various visual tools, would normally be undertaken at the initial stages of the evaluation process as they often provide the basis for the design of in-depth questionnaires for semi-structured interviews

and the conduct of focus groups.

Mixed Methods for Rapid Data Collection; Focus on Qualitative

LTL Strategies is aware of the relatively short amount of time available to conduct the fieldwork for this evaluation, and of the need to "hit the ground running." We will consult closely with our colleagues from USAID/EA, as well as with the representatives of implementing partners Pathfinder and IntraHealth to quickly get an initial sense of the literacy levels of our intended interlocutors, as well as of the methods they have already used to collect information. We will also inquire of, and carefully consider, the types of groups to be interviewed (e.g. youth groups, women's groups, gender-based violence victims, first response care providers, community leaders, etc.). Based on this information, we will adjust this questionnaire and approach on the ground, on an *interlocutor-type-by-interlocutor-type* basis.

LTL will employ a mixed methods (quantitative and qualitative) strategy. LTL's proposed methodology is based on a philosophy of the importance of appreciative inquiry. In designing the mid-term performance evaluation, LTL will use an appreciative inquiry approach – "What worked, and how can we get more of it?" LTL's commitment to appreciative inquiry is predicated on an assets-based approach (towards both the suppliers and consumers of a program or service) that assumes that a) there is always something useful that comes out of program design and implementation, despite any challenges that may have occurred; and b) that there are tangible, and sometimes unidentified organic resources of excellence among beneficiary groups.

In addition to a review of project documents to include the monitoring plan (especially benchmarks) established in the initial program document, LTL will conduct a mix of key stakeholder interviews and focus groups, and assess quantitative data (to the extent that it is available) to perform this evaluation.

While quantitative questionnaires are structured in the variety of answers that a respondent chooses from, qualitative surveys and focus groups allow for more nuanced, semi-structured and open-ended responses. The objective of qualitative designs is to capture values, attitudes, and preferences of participants to permeate the 'how' and the 'why' underlying a phenomenon. Since data resulting from qualitative research approaches does not lend itself to numerical coding, evaluation of qualitative findings is more complex compared to quantitative research results. Tables, rows of data, or correlations are therefore not generated by qualitative research. Information collected will be grouped under topical headings and generalized in its diversity.

Guiding Principles: Developmental Evaluation in Conflict Situations

As we noted in our proposal, our approach will be based on careful consultation and collaboration with the Missions in Burundi, the DRC, and USAID/East Africa. Our overall approach is designed to support USAID/East Africa's objective of assessing Flex FP's success, and in extracting [potentially replicable] lessons learned about providing useful reproductive health services in crisis –particularly conflict—situations.

Conflict, conflict transition, post-conflict reconstruction, and conflict-prone situations are complex by nature, and challenging to evaluate. Part of the challenge in evaluating conflict situations is that "causes" (conflict drivers and conflict triggers) are difficult to isolate, often rendering -–at best— a somewhat weak type of correlation that many evaluators may hasten to qualify as "inputs" that lead to the "effect": conflict (or "outcome"). LTL understands that correlation is by no means definitively causality, and that when it comes to evaluating program efforts in conflict situations, complexity concepts must be considered and integrated. Complexity concepts can be used to identify and frame a set of evaluation approaches and [ultimately] program interventions appropriate to the often ambiguous and unpredictable nature of conflict contexts. Complexity concepts can be applied to enhance innovation and use in an evaluation mode known as *Developmental Evaluation.*[3] Developmental evaluation is a dynamic evaluation approach that goes beyond the classically summative (and often static) assessment in order to extract lessons learned or best practices to *develop* something:

- A new program or policy based on medium- or long-term impact attributable to the distinct complexities *and* cross-cutting elements of conflict contexts;

- A rapid response based on a sudden major change in a conflict-prone or conflict environment (emergency humanitarian assistance that also needs to support medium-term development goals in a country); or

- An adaptive program effort designed to take an innovation to scale to increase impact and contribute to major systems change.[4]

Differentiating between Outcome and Impact

Outcomes

- Has the Flex FP program successfully identified approaches for developing models of a minimum package of family planning and GBV services to offer during emergency or unstable situations? What criteria do

[3] Patton, Michael Quinn, 2011. *Developmental Evaluation: Applying Complexity Concepts to Enhance Innovation and Use* (New York and London: Guilford Press).
[4] *Ibidem*. See Chapter 7: The Adaptive Cycle

the program implementers use to analyze this? How do the intended beneficiaries analyze this?

- Has Flex FP been able to realize an "early planning" strategy (e.g., in an unstable or potentially explosive socio-political situation, has the program been able to predict and prevent, or reduce the occurrence of rape?) If so, is this strategy applicable beyond Burundi and the DRC?
- Has a core cadre of trainers been developed? If so, how effective has it been in training others (numbers and impact of those trained on other communities)? If not, what were the impediments to establishing this core cadre of trainers, and how might this obstacle/these obstacles be overcome in the future?
- Has Flex FP been able to establish mobile outreach teams? If not, why not?
- Has Flex FP been able to establish and successfully run 24-hour drop-in centers? I fnot, why not?
- Has Flex FP provided post-rape and GBV services? If not, why not?
- Has Flex FP been able to develop and test community-based distribution of Depo Provera?

Impact

- Has the impact of the services provided (drop-in centers, training of core cadre of trainers, post-rape counseling, contraceptives distribution, etc.) been the same in Burundi's Muyinga and Kayanza provinces as in the DRC's Bukavu? Why or why not?
- Has the Flex FP project had an impact on perceptions of women's human, social, and reproductive health rights in the communities in which it has been implemented? Why or why not?
- What has been community reaction to the distribution of Depo Provera? To what extent has religion or culture played in role in that reaction? Why or why not?
- Has the Flex FP project successfully collaborated with agencies working in the humanitarian aid field, and with those offering reproductive services and family planning and gender-based violence? If so, has this resulted in any kind of integrated emergency services among various agencies/organizations providing health services in crisis areas? If not, why not?
- How, if at all, has the Flex FP project affected border community relations between Burundi and the DRC?

Interview Guide

1.) Overall project performance *(Questions to be asked not only of implementing partners - Pathfinder and IntraHealth – but also, selectively, of principal stakeholders, notably Ministries of Health and NGOs in Burundi and the DRC with which the project has interacted.)*

- What have been the principal achievements and challenges of the Flex FP project in reaching vulnerable populations with family planning and reproductive health services?
- How successful has the project been in reaching out in new and coherent ways to victims of sexual violence to provide them with dependable counseling and services?
- The project was designed to develop and test "flexible approaches" or models of service delivery to communities in different crisis situations. Has it done so, and which models have been most successful?
- To what extent have the project and its inputs contributed to strengthened quality and integration of services at national, provincial and community levels?
- To what extent has the project contributed to the strengthening of national health care policies, including contraception-related policies, as regards delivery of services to vulnerable populations?
- What is the project leaving behind? In other words, how much of what it has initiated will be sustainable over the long term?

2.) Access to services *(Questions to be asked of health authorities and service providers at provincial and health facility levels.)*

- How has the menu of service delivery options tested by the Flex FP project been applied to increasing access to FP, RH and GBV services for vulnerable populations? How have they complemented existing public health services? What is the likelihood that these new services will continue to be provided with the ending of project financial support?
- Please describe the steps involved, and any obstacles encountered, in implementation of the Minimum Initial Service Package (MISP) for reproductive health.
- Please comment on the strengths and weaknesses of such innovations as 24-hour service delivery; mobile outreach teams; Healthy Images of Manhood (HIM) activities.
- Is access to contraceptive services, including community-based distribution of injectables and other contraceptives, as well as emergency contraception, assured in your area or facility? What are the obstacles, if any, to complete access?
- What are the principal challenges to FP/RH/GBV service access, and how has the Flex FP project strengthened such access?

3.) Quality of services *(*Questions *to be asked of health authorities, service providers, and, where appropriate, clients at provincial, health facility and community levels.)*

- How have Flex FP project interventions and innovations enhanced the quality of services provided to vulnerable populations in your area?
- What training or retraining has been provided under the Flex FP project? Please comment on its quality and comprehensiveness. In what areas do you feel that more training was/is needed? Has follow-up of trainees been effective? Will training continue to be available after cessation of project activities?
- How does quality and comprehensiveness of services offered at static health facilities compare with those provided by integrated mobile outreach teams (IMT)?
- How have IMT services evolved over the life of the Flex FP project? Which services provided by IMTs are most appreciated? What is the follow-up system for patients served by IMTs?
- Have supplies of contraceptives and other drugs and clinical materials provided by IMTs and static clinics been dependable?
- What role to community health workers (CHW) play in providing information and services in the community? To what extent has community outreach by the FlexFP project resulted in increased knowledge and more positive behaviors at community level?

4.) Collaboration and coordination *(Questions to be asked of MOH and NGO representatives at national and provincial levels.)*

- How effective has coordination been between those implementing the Flex FP project, the MOH and local health authorities? Have there been significant obstacles, such as communication breakdowns or policy differences, that have hindered complete “buy-in” to the project on the part of these authorities?
- How effective has coordination been between those implementing the project and local NGOs (such as ABUBEF in Burundi) as well as with international organizations?
- Have the different approaches and models developed through the project (IMTs, 24-hour services, etc.) been well coordinated and complimentary?

5.) Sustainability and scaling up *(To be explored at all levels. This question will be asked in different ways on several occasions, because it is a key question for the future.)*

- Which approaches/models developed under the project will be/are being maintained following termination of the project?

- Which aspects of the FlexFP project have greatest potential for replication or scaling up, at regional or country level, should additional funding be available?

ANNEX 2
PERSONS CONTACTED

BURUNDI

Dr. Juma Ndereye	Directeur, PNSR
Dr. Irenée	Directeur des Services de Programme de Santé
Josiane Karirengera	Coordinatrice, Centre Seruka
Mme. Léoncie	Chargé Programmes des Jeunes, ABUBEF
Dr. Eric Manirakita	Médecin Directeur, Province de Muyinga
Dr. Alexis	Superviseur, District Sanitaire de Muyinga
Dr. Jean Baptiste	Médecin Chef, District Sanitaire de Gasholo
Dr. Nestor	Superviseur, District Sanitaire de Giterangi
Jean Buchman Mpabansi	Principal Advisor, Governor of Muyinga
Jean-Baptiste Rumditse	Nurse-in-charge, Kinazi Health Center
Community leaders	Nyarunazi Peace Village (IDP camp)
HIM Champions	Commune de Gasorwe
M. Athanase	Gouverneur, Province de Kayanza
Dr. Jean Nepo	Chef de District Sanitaire de Kayanza
Nurse-in-charge	Centre de Santé, Rubura

DRC

Dr. R. Nyamugaragaza	Directeur, PNSR, Province Sud-Kivu
Estelle Bahati	Superviseur, PNSR, Sud-Kivu
Dr. Renée	Médecin Chef de Zone de Santé, Walungu
Nurse-in-charge	Centre de Santé de Référence, Bideka
Crispin Ishingwa	Centre d'Information pour le Pays (civil society org.)
Nurse-in-charge	Centre de Santé, Kibododo
Integrated mobile team	Mugogo
Dr. Julien Mbalama	Médecin Chef de Zone de Santé, Miti
Rafiki Mulihand	Administrateur et Gestionnaire, Miti
Godefroid Mayala, MD	FP & RH Mgt. Specialist, USAID/Kinshasa

PROJECT TEAM *(partial listing; all Pathfinder unless otherwise noted)*

Tanou Diallo	Chief of Party
Chantal Inamahoro	Deputy COP
Theoneste Nimpagaritse	FP/MCH
Diane Nezerwe	Project Officer
Jean Paul Niyibigira	M&E
Franck Akamba	Field Coordinator, DRC
Tharcisse Niyonizigiye	IEC/HIM InItiative (IntraHealth)
Jaques and Napoleon	Drivers

USAID/EA

Julia Henn	USAID/EA/RHH Director for Technical Support
Wairimu Gakuo	USAID/EA/RHH Strategic Information Specialist

ANNEX 3
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(A listing of some of the documents consulted for this evaluation.)

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Healthy Images of Manhood, IntraHealth International, January 2013

Burundi, Internal Mid-term Review, Flexible Family Planning, Reproductive Health and Gender-based Violence Services for Transition Situations, October 2010, Cathy Solter and others

Burundi Flex FP Project Proposal, 2008

ANNEX 4

EVALUATION TIMETABLE

BURUNDI

March 18, Bujumbura - briefings with Pathfinder and IntraHealth Flex FP project staff; meetings with Dr. Irenée and Dr. Juma of the Burundian MOH; visit to the Seruka Referral Center for victims of sexual violence, as well as the site used for training in treatment of SGBV over the life of the project.

March 19-20, Muyinga Province – meet with provincial and district health officials; visit to Nyungu District Health Center and IMT site; visit to Kinazi Health Center, refurbished with project assistance, and Mugano Peace Camp (no longer populated); visit to Nyarunazi Peace Camp for IDPs; visit to Gasorwe Commune and Refugee Camp to meet with HIM "champions"; FGDs with CBD agents and beneficiaries at health center and community levels.

March 21-22, Kayanza Province – meetings with provincial and district health officials; visit to Rubura Health Center, refurbished with project assistance; visit to Nyarurama IDP Camp and Health Center, also refurbished with project assistance; visit to Rugogwe *colline* to see District IMT in action; FGDs with CBDs and beneficiaries.

March 29, Bujumbura - visit to ABUBEF and follow-up visit to Seruka Center; debrief on evaluation to date with USAID/Burundi.

DRC

March 25 – travel from Bujumbura to Bukavu; meet with Pathfinder DRC team; discussion with Dr. Nyamugaragaza, Director, PNSR, South Kivu Province.

March 26 – accompanied by Walungu Health Zone officials, visit to Walungu Hospital and referral clinic, renovated and equipped by the Flex FP project; FGDs with service providers, CBDs, beneficiaries and HIM peer educators (the equivalent of HIM champions in Burundi); visit to Bideka Health Center; FGDs with CBDs and beneficiaries.

March 27 – return to Walungu Health Zone to meet civil society organizations to discuss HIM model; visit to Kidodobo Health Center, refurbished by project, for FGDs with CBDs and beneficiaries; visit to Kavumu Health Center, refurbished with project assistance; lengthy visit with IMT in action in remote rural area.

March 28 – travel to Miti Health Zone to meet with local officials and discuss the future "after Flex FP"; visit to Kavumu Health Center; FGDs with HIM peer educators, CBD agents, beneficiaries. Brief meeting with USAID/Kinshasa staff person in Bukavu to update him on evaluation team activity.