Regional Report

Multi-country Evaluation of the Community Health Programme/Strategy

in Guinea-Bissau, Central African Republic, and Chad

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We hope that the insights from this regional and country reports shall add value in further refining the community health policies, strategies, and programmes in the region. We wish the UNICEF Regional and Country Offices, the national governments and their partners, the development partners. and donors well in their future undertakings and partnerships for saving and improving the lives of women and children in the West and Central Africa region.

On behalf of the Evaluation Team,

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List of Acronyms

Acronym	Full Form (English)
AoR	Areas of Responsibility
BMGF	Bill & Melinda Gates Foundation
CA	Contribution Analysis
CAP	Complementary Activity Package
CAR	Central Africa Republic
CBHS	Community-based health services
CBOs	Community-based organizations
CBVP	Community Based Vaccination Promotion
CO	Country Office
CCO	Chad Country Office
CCS	Community Care Site Assessment
CFC-RTM	Child Friendly Community initiative with Real Time Monitoring
CH	Community Health
CHP	Community Health Programme
CHSP	Community Health Strategic Plan
CHWs	Community Health Workers
CRC	Convention on the Rights of Children
CSOs	Civil society organizations
DHD	Regional Health Delegation
DHS-MICS	Demographic and Health Survey and Multiple Indicators in Chad
DHSOFM	Directorate of Health Services Organization and Funding Mechanisms
EM	Evaluation Matrix
EPI	Expanded Programme on Immunization
ERG	Evaluation Reference Group
FGDs	Focus groups discussion
GB	Guinea-Bissau
GoGB	Government of Guinea-Bissau
GoCAR	Government of CAR
GoChad	Government of Chad
GPEI	Global Polio Eradication Initiative
HISD	Health Information System Directorate
HRBA	Human Rights Based Approach
iCCM	Integrated Community Case Management
IMCI	Integrated management of childhood illnesses
KIIs	Key informant Interviews
KPC	Knowledge, practices, and coverage
LB	Live Births
MoH	Ministry of Health
MoPH	Ministry of Public Health
MoHP	Ministry of Health and Population
MoPHNS	Ministry of Public Health and National Solidarity
MPA	Minimum Package of Activities
NGO	Non-governmental organizations
NHDP	National Health Development Plan

NHP	National Health Policy
NISEDS	National Institute of Statistics, Economic and Demographic Studies
OECD - DAC	Organization for Economic Co-operation and Development Assistance Committee
RO	Regional Office
RHP	Regional Health Delegation
SAARSD	Sahelian Alliance for Applied Research for Sustainable Development
SDGs	Sustainable Development Goals
SPSS	Statistical Package for the Social Sciences
UHC	Universal Health Coverage
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WASH	Water, Sanitation and Hygiene
WB	World Bank
WCAR	West and Central Africa Region
WCARO	Western and Central Africa Regional Office
WHO	World Health Organization

Executive Summary

Introduction: This report presents the findings, conclusions and recommendations of the regional evaluation covering not only the Community Health Programme (CHP) in **Guinea-Bissau** but also the Community Health (CH) approaches and strategies promoted and implemented by the United Nations Children's Fund (UNICEF) along with its national partners in **Chad and the Central African Republic.** The strategic value of this evaluation is quite apparent as Community Health (CH) is a growing national priority in the West and Central Africa Region (WCAR), as illustrated by the fact that 20 of its 24 countries have put in place a national CH programme within an increasingly ambitious CH policy framework. That notwithstanding, the integration of CH approaches/strategies into national health systems across the region remains rather weak. As a result, UNICEF is working on strengthening CH programming both at country and regional level, making sure that the most deprived children and families have a more adequate access to quality health services. The CH Programme, hereinafter referred to as the Programme, aimed to assist the three countries' governments in reducing maternal, neonatal, and child mortality through the provision of a more equitable access to essential care. In GB, the primary beneficiaries are pregnant and lactating women (414,941) and children under 5 (226, 189). In CAR, the programme targeted to reach to 76000 children and has benefitted children under 5 years of age (U5) by treating 81,197 cases[1] of 3 diseases (40,288 girls and 40,909 boys) including the identification and referral of malnutrition cases. In Chad, the CH approaches and strategies benefitted a total of 10,605,215 (direct and indirect) beneficiaries[1]. In order to attain the Programme objectives, UNICEF worked closely with health ministries, regional/provincial health teams, I/NGOs, and multiple technical and financial partners. The evaluation was conducted by AAN Associates (hereinafter referred to as 'the evaluators') and executed under close supervision and involvement of the three UNICEF Country Offices concerned by this evaluation as well as the UNICEF's Western and Central African Regional Office (WCARO). The evaluation, which faced multiple constraints (COVID-19 restrictions, delays in acquisition of ethical approvals and of secondary data), was undertaken between February 2020 and December 2021. The evaluation was conducted according to the scope and methodology outlined in the evaluation Terms of Reference (ToRs), issued by UNICEF (See Appendix 01).

Context and Intervention: As of 2018, the Sub-Saharan African region had the highest under-five (U5) mortality rate (78 deaths per 1,000 live births) in the world, accounting for more than 80% of the 5.3 million deaths in children U5 along with Central and Southern Asia.[2] The situation today is still not any different for the WCAR countries concerned by this evaluation (GB, Chad and CAR). In order to tackle their respective high U5 mortality rates, the three countries' Governments are striving to adopt a series of measures including the prioritizazion of community health (CH) interventions during the development and implementation of national health plans. Such was the case for (a) the National Health Development Plan (NHDP) II 2008-2017 & NHDP III for 2018-2022, the Operational Plan to Scale up High Impact Intervention for the Reduction of Maternal and Child Mortality (POPEN 2010-2015) and the national Community Health Strategic Plan (CHSP 2016-2019) in GB; (b) the NHDP II (2013-2015), NHDP III (2018-2021) and the National Strategic Plan for implementing Universal Health Coverage (2017-2019) in Chad; and, lastly, (c) the National Health Development Plan 2006-2015, the Transition Plan 2014-2015 and the Health Sector Interim Plan (HSI) in CAR. All these plans share the common objective to *'accelerate reduction of maternal and child health mortality'* and advocate for the implementation of CH programmes and approaches at the national level. While the governments' commitment and efforts in the three countries are commendable, weaknesses characterizing their respective health systems and the rather low technical and financial capacities amongst in-country actors triggered the UNICEF involvement (both Country Offices and Regional Office) in the CH area, mainly through the provision of technical and financial support. In this vein, UNICEF specifically advocated to the 3 Governments to employ, train and equip Community Health Workers (CHW) and engage both communities and health staff at the local tier of health systems as a way to reduce their worrying high U5 mortality rates.

The object of the evaluation comprised the CH Programme (CHP) in GB as well as the CH approaches in CAR and Chad. Beyond the specificities of each one the 3 countries, the CHP strategies and the CH approaches equally focused on the provision of promotional interventions, preventive care

[1] The above calculated number of beneficiaries are liable to "double counting". For example, one child may have received different vaccines and multiple doses. Also, one pregnant women or family member has been consulted multiple times by CHWs or she may also have visited the health facility for pre-post-natal visit and for her children vaccination. It is not possible to calculate unique value of beneficiaries due to data limitation in the available reports.

[2] https://childmortality.org/wp-content/uploads/2019/10/UN-IGME-Child-Mortality-Report-2019.pdf; https://www.unicef.org/reports/levels-and-trends-child-mortality-report-2019

for pregnant and lactating mothers, and curative services for three most lethal child diseases (pneumonia, diarrhoea, and malaria) and quality nutrition services. The Ministry of Health (MoH) in each country was the public entity leading the development of the CH strategies and approaches whereas the implementation was taken care of by an average of 4-6 I/NGOs (in each country) under UNICEF direct technical and financial support. In the three countries, the EU remains the key donor (specifically in GB and CAR) along with technical and financial support of other partners (UNFPA, World Bank, Bill & Melinda Gates Foundation, Global Fund and Swiss Cooperation). The CH Programme budget was €6 million, and €4.5 million in GB and CAR respectively; and $5.7 million for CH Approaches in Chad.

Purpose and Objectives the Evaluation: For GB and Chad, the evaluation is 'formative' with an explicit learning purpose whereas in CAR, the evaluation is summative with a double purpose (focus on learning and accountability to both funders and populations groups in the field). In line with the established purposes, the evaluation objectives have been as follows: 1) to assess the degree to which the set objectives have been achieved; ii) to identify the lessons learned during the implementation of the national CH strategic framework in GB as well as of all the other CH approaches in CAR and Chad; iii) to assess UNICEF contributions to the CH strategic results; and iv) to formulate key recommendations to improve implementation and performance of CH programmes and strategies across the region.

The evaluation thematic scope: The evaluation covers all CH interventions or approaches implemented in each country under the purview of the respective national CH operational/strategic plans.

The evaluation chronological scope: the evaluation focuses on all the CHP activities and CH approaches implemented between January 2016 and September 2019.

The geographical scope: the literature review covered all the regions in the 3 countries where CH interventions were implemented through UNICEF financial and technical support (11 health regions in GB, 06 Prefectures in CAR; and it covered all approaches implemented under CHSP across Chad). However, the fieldwork concentrated on a restricted and yet representative number of sites (see sampling section for more details).

Evaluation Criteria and Questions: In order to fulfil the evaluation envisaged purpose and objectives, the evaluation team's work was guided by 5 criteria: four OECD-DAC[3] criteria (relevance, efficiency, effectiveness, and sustainability)[4].; and 1 additional one (referred to as non-DAC criterion) pertaining to gender equality, equity, and human rights-based programming (HRBA). The evaluation team sought to find answers to seven key evaluations questions (with 13 sub-questions), as spelled out in the Evaluation Matrix (see Appendix 16 for more details).

Evaluation Design and Methodology: The evaluation was guided by two overarching approaches - '**Mixed Method'**[5] and '**Participatory**[6]**'.** A 'Hybrid' evaluation design was proposed and applied to meet the evaluation expectations keeping in view data availability (both primary and secondary) and Programme design. The design includes two sub-designs i.e., **Contribution Analysis** and **Experimental** (featuring 'Single Group Pre- and Post-Test' technique/approach)[7,8].

The evaluation relied on a '**Mixed Method'** approach featuring both qualitative and quantitative methods for primary data collection. The evaluation design and methods took a considered view to be able to integrate and assess the UNICEF programming priorities of HRBA, gender equality and equity. For desk review, the Evaluation team reviewed **562 documents** (377 for GB, 108 for Chad, and 77 for CAR) shared by UNICEF. The quantitative data collection included a household survey administered to 400 mothers (who have at least one child U5) in each of the 3 countries. Additionally, for CAR, 10 community care sites were surveyed. For qualitative data collection, **84 Key Informant Interviews (KIIs)** were conducted (36 in GB, 23 in Chad and 25 in CAR) with various stakeholders from Governments, UNICEF, implementing partners (I/NGOs), focal persons from EU and other partners (WB, UNDP). Also, a total of **83 FGDs** (30 in GB, 23 in Chad and 30 in CAR) were conducted for a total of **634 participants** (54% male and 46% female) including mothers, community members, CHWs and

[3] Development Assistance Committee (DAC) / Organisation for Economic Co-operation and Development (OECD)
[4] ToRs does not require assessment of impact and coherence)
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5602001/pdf/11577_2017_Article_454.pdf
[6] https://www.betterevaluation.org
[7] https://methods.sagepub.com/reference/the-sage-encyclopedia-of-communication-research-methods/i9778.xml
[8] https://www.betterevaluation.org/en/plan/approach/contribution_analysis

staff from NGOs and health facilities. Following the field data collection, a consultative online session with ERG members was convened in each one of the three countries to; a) verify the accuracy of the information gathered during the field work; b) facilitate joint reflections on some of the emerging findings; and c) obtain a preliminary validation of the first set of preliminary findings and conclusions so as to have a more stable evidence base to formulate the strategic and operational of recommendations. Data analysis was undertaken by using of **Statistical Package for the Social Sciences (SPSS) and** MAXQDA[9] tools and Excel-based techniques.

Evaluation intended audiences and respective uses: The key expected users of this evaluation are the UNICEF WCARO, UNICEF Country Office (CO) and the Ministry of Health of the three countries as well as of the rest of the region, the implementing partners and other development partners providing funding to CH interventions and related technical assistance across the region. The main expected uses of the evaluation are threefold and consists of a) the strengthening of similar programs and strategic approaches across the region in the future based on the lessons learned and identified good practices; b) the allocation of resources based on what approaches have proved to be the most efficient; c) the implementation of similar programs in the future based on the activities and on delivery modalities that have contributed to the greatest achievements. More specifically, the evaluation intended audiences and respective used are summarized below:

National Governments / MoH	To inform the revision of the national CH strategies and strategic plans and decisions on CH investments, future engagement with UNICEF for potential handover to respective governments in each country.
Implementing Partners (IPs)	To adopt key lessons, good practices, and recommendations in their future implementation for optimization of resources and results.
UNICEF CO	GB: To extract lessons to redefine CH investments in the new CPD development. Chad: The Health section in the UNICEF CO intends to a) support advocacy for a more inclusive CH policy; b) focus CH interventions considering the evaluation findings; and c) understand how the community approach can drive a dynamic in achieving key results for children. CAR: To support advocacy for a more inclusive and CH policy and refocus CH interventions considering the evaluation findings.
UNICEF WCARO	To better support Governments in each country towards institutionalization of CH approaches/strategies; and to disseminate good practices and lessons learned with other regions.
Donors	To review future relationships with governments, UNICEF and other partners and decision on future investments on CH in three countries and in the region.

Evaluation Key Findings and conclusions (by criterion)

Relevance: All CH interventions in three countries are aligned with national and health sector priorities. The key stakeholders referred to CHP strategies and interventions[10] as relevant for prioritizing and addressing the health system bottlenecks at the community level across the 3 countries, such as the weak technical, administrative and implementation capacities amongst local health actors, the shortage of human resources and the rather poor health infrastructure UNICEF and partners' assistance enabled the respective Governments to implement their CH strategic plans which were developed and rolled out to promote and implement health interventions at community level with involvement of trained CHWs. The interventions are considered relevant for prioritising child centred diseases (pneumonia, malaria, diarrhoea) and malnutrition with high contribution to child morbidity and mortality. Also, CHP is aligned with the Governments' efforts to follow through their respective national and international commitments (Universal Health Coverage, Bamako Initiative, SDG 3.2, Convention on the Rights of the Child - CRC, and others). Moreover, the CH interventions appeared to be largely compliant with national and international guidelines (particularly of WHO guidelines on CH Programme and policies)[11] pertaining to community health programming. That notwithstanding, certain aspects of the CH interventions on the ground are not in par with the global and national strategic priorities and orientations (e.g., the CHW

[9] MAXQDA is a software program designed for computer-assisted qualitative and mixed methods data, text and multimedia analysis in academic, scientific, and business institutions.
[10] Capacitating the RHDs and health area staff, establishing CHW network, mobile and advance strategies, door to door visits by CHWs, implementation of EFPs, provision of medicines etc.
[11] WHO guideline on health policy and system support to optimize community health worker programmes 2018; https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf?ua=1&ua=1; Updated Programme Functionality Matrix for Optimizing Community Health Programs (2018); https://www.unicef.org/media/58176/file

recruitment criteria, the low level of compensation (The incentives paid to CHWs are far less as are suggested by national guidelines of the countries; also the CHWs payment vary from partner to partner in GB and Chad), no career ladder and no formal certification for CHWs, and limited IT use in CH).

Effectiveness: With respect to the degree to which the CH programme and approaches in the three countries attained their expected results, the conclusion is that they did so only partially. For instance, only 20% of CHSP activities planned in Chad could be implemented and the Programme in CAR could only manage to treat 27% of the planned cases (for the three targeted diseases in children U5). In GB, out of the eleven outcome level indicators[12] (see Table 4.3 for details), the Programme managed to achieve (either fully or partially) the targets associated with 8 of them ; it did not achieve 2 of them; for the remaining indicator, performance could not be assessed due to data limitations).That said, the trends suggest an encouraging reduction in child mortality rate in GB (mortality among children under five is reduced from 89/1000 live births (MICS5 2014) to 51/1000 live births (MICS6 2019); and little progress in CAR (U5 child mortality reduced from 103/1000 LB (MICS 2010) to 99/1000 LB (MICS 2019).

The interventions across the three countries have been successful in placing CH as public policy priority on health managers' agenda. Moreover, the joint implementation by Government and implementing partners (IPs) of CH programmes has enabled public officials to get first-hand experience of managing/contributing to CHP delivery. For Chad, the detailed analysis of results and achievements of these approaches yielded an assessment of 'Partially Effective' for the 3 approaches namely (i) Community Based Vaccination Promotion (CBVP); (ii) Child Friendly Communities Initiative with Real Time Monitoring (CFC-RTM); and (iii) Integrated Community Case Management (iCCM). Furthermore, the '1000 days approach for prevention of malnutrition' is assessed as 'Mostly Effective' and the initiative of 'Training of 1000 CHWs' is rated as 'Fully Effective'. For CAR, the Programme's key contributions are evident in terms of enhancing the Government's commitment to the CH cause, drafting the first CH Policy, developing a CH implementation guide, providing training to a cadre of master trainers and 193 CHWs, and establishing 193 community care sites.

Less effective has been the integration of CHW into formal health system as attested by the fact that their accreditation was assessed as 'not functional' in any of the three countries. In addition, based on the WHO CHW-AIM Functionality Matrix tool, both the CHW and CH Programmes are judged [13] with varied level of achievements or gaps (around 10 thematic components). On a relative comparative basis, the CHW performance is weaker in Chad (31%) than in GB (41%) and CAR (44%).

On the partnership front, the engagement of national or international non-governmental organizations (I/NGOs) as IPs has proven effective in enabling public sector to produce some results. However, in CAR, the initiation of the Programme and implementation faced delays on account of factors such as contracting and mobilisation of partners. In addition, monitoring, and supervision remained inadequate and is concluded as less effective in all three countries. In GB, the role of the MoPH to support the Programme was rather limited as the Programme was implemented in isolation of those two key Ministries (Finance and Planning) whose influence in mobilizing more public funds could not be leveraged effectively. At regional level, the relationship between UNICEF and both implementing partners (IPs) and regional directorates was effective to plan activities, review implementation progresses and resolve challenges on the ground. The UNICEF's collaboration with World Bank (WB) was particularly effective as it resulted in leveraging WB funds for payments to CHWs. In Chad, a critical conclusion about partners' role is that each of them is implementing the MoPH agenda in isolation from all others which, resulted into lack of geographic convergence, inconsistent implementation, and weak integration of CH interventions into the national and sub-national health system. This apparent lack of coordination was also aggravated by the concerns that partners have over, rather weak degree of, the involvement and leadership demonstrated by the MoPH. The role of MoPH in CAR is an exception to that: the UNICEF partnership with MoPH in the country has worked well in gaining ministry's involvement, commitment, and support for the Programme. The partnership resulted in defining and executing programme management arrangements within MoPH and contributed to the development

[12] 2 indicators achieved/overachieved (ANC4 rate; children U5 sleeping under LLINs); 8 indicators almost/mostly achieved (exclusive breastfeeding; immunization coverage; delivery by trained personnel; children U5 with malaria treated properly; children U5 with pneumonia treated with antibiotics; children U5 having diarrhoea treated with ORS & Zinc); 2 indicators not achieved (C.U5 with growth retardation; and C.U5 with global acute malnutrition); 1 indicator not assessed 'rate of outpatient for children U5)

[13] WHO assessment scale a) Non-Functional, b) Partially Functional, c) Functional, and d) Highly Functional.

and approval of some essential documents (training materials, implementation guide) that were required for the Programme implementation.

Efficiency: The Programme implementation is concluded as "partially efficient". In CAR, 3% of the allocated funds remined unspent despite the 12 months of no cost extension granted to complete implementation on the ground. In addition, funds (amount and distribution to cover key programmatic aspects of monitoring, supervision, and logistics) were clearly described as inadequate for GB and Chad by most stakeholders. For CAR, due to delayed onset and slow pace of implementation, the funds utilization rate was uneven whereby only 17% of funds could be utilized in first two years, and cumulatively almost 51% of funds were utilized in first three of the total four years implementation. On the human resources front, in all three countries CH interventions and approaches were implemented with minimum of resources as well as low to moderate technical capacities of the Government staff as well as of I/NGOs and of UNICEF (specifically in CAR). These constraints led to various operational inefficiencies (weak coordination, monitoring and supervision of CHW activities, low quality of activities on the ground, and incomplete data collection on CH). In terms of availability of medicines and supplies, although the situation in CAR was relatively better than in GB and Chad, instances of shortages of some medicines (ORS, Zinc, paracetamol, antimalarials) and supplies (office items, fuel for generators, repair, and maintenance of motorcycles) were recorded in all 3 countries. The implementation in all three countries is characterized by a generally slow onset, several contractual issues with the management of NGOs and a certain number of delays in the implementation of different activities (due to both internal and external factors) which resulted in: a) the signing of multiple contracts with I/NGOs (GB); b) varied implementation duration for different CH approaches (Chad); and seeking no-cost extensions (of 12 months) in CAR. That notwithstanding and despite its being regarded by most stakeholders as an expensive strategy, the, implementation through I/NGOs was considered necessary to fill the operational capacity gaps existing within the public sector.

Sustainability: In all three countries, CH Programme and approaches have weak sustainability prospects for various reasons mainly due to reliance on donor support, limited technical and financial capacities of public partners and limited capacities of communities to support CHW work and CH interventions. In Chad and CAR, a clear 'exit plan' or 'sustainability roadmap' was missing, whereas in GB a 'transition or exit plan' was developed during CHP implementation but could not be implemented fully, despite the government and partners sharing a clear intent to implement it in the future. With respect to the level of Governments' ownership and commitment, some notable achievements are more evident in GB and CAR (especially in terms of CH institutionalization), than Chad where the Government has not yet taken concreate measures and actions to support CH implementation. The lack of concrete commitment by governments to CH, and the unavailability of a budget line for community health remains a challenge to sustaining the CH interventions or the results thereof across the 3 Countries. Eventually, the MoPH in 3 countries are fully dependent on continued external support (both technical and financial). Moreover, uncertainties exist around the availability of donor funds for CH in the future.

Gender Equality, HRBA and Equity:

Integration of Gender Equality: Across all countries, no gender specific assessment was undertaken to inform the Programme design. However, CH interventions and approaches are assessed as gender sensitive. That said, at implementation level, although a mix of gender responsive strategies were implemented across 3 countries, their success, and contributions to address gender barriers (knowledge gap, lack of access due to long distances, and cost implications for seeking health care) remain insignificant across 3 countries. Despite all CH approaches aiming to attain optimum or equal ratio of female CHWs, the female participation as CHWs in all 3 countries remain inadequate (GB 21%, Chad 20-30%, and CAR 34%).

HRBA: Across all countries, the Programme's design and implementation is assessed as mostly compliant with HRBA principles. Participation of duty bearers was encouraged at the design level and of right holders (communities, women, and men) during implementation. Nevertheless, one weak element observed in all 3 Countries, is the inadequate level of community participation except during the identification of CHWs. On the accountability front, the evaluation team observed a rather weak accountability culture within public sector entities (at national, regional and health district levels) including the lack of integration with local governance structures (except in Chad where under CFC-RTM approach, some level of involvement of local government is evident with low to moderate level of responsiveness from the local government). The non-existence of complaint mechanisms at community level in all three countries further undermines compliance to HRBA principles.

Equity: Across all countries, equity integration is visible at the design level. However, during implementation, the compliance with equity considerations remained 'partial'. Regardless of the scale and coverage, in each country, there are few strategies or interventions which demonstrate adherence to equity (such as prioritization of remote communities, provision of free medicines and services for all groups, execution of mobile strategies to provide services at the doorstep in remote/isolated communities, the set-up of baby-friendly mothers groups, and launch of income-generating activities though under CFC/RTM). The evaluators did note limited focus on integrating other equity or identity features that may affect access to healthcare such as poverty, religion and ethnicity, disability, and others.

Lessons Learned

I. The adoption of an implementation approach involving both public agencies and I/NGOs is appropriate in contexts (as was the case in all 3 countries under the evaluation) with limited healthcare outreach, and dearth of technical capacities and exposure to CH programming.

II. The paired deployment of CHWs (whereby men and women are recruited and deployed together) prove effective (for instance in Chad during pilot implementation of iCCM in 2019) in overcoming the gendered divisions and enabled access to both men and women. This warrants replicability and continuity in future particularly in socially conservative communities in other countries.

III. The use of visual materials/aids for training of CHWs (mostly being either un-educated or with limited education) proves useful and effective in better understanding and promoting the internalisation of contents. Similarly, the post training follow-up and contact with CHWs help in taking stock of localised challenges and engaging with CHWs to find and apply context specific solutions.

IV. The engagement with local groups or committees (community committees, women groups etc) proves useful in mobilising communities, cultivate ownership and support within communities. The weak linkages of CHWs with formal health systems, together with low compensations for CHWs, contribute to low morale and motivation of CHWs. The limited educational attainments of CHWs generally hinder them to understand the complexities of monitoring tools and reporting, which need to be simplified for future. With low to moderate degree, this lesson applies to all three countries under this evaluation.

Recommendations

The following recommendations rest on the findings and conclusions presented above. The recommendations were discussed and validated by the UNICEF Regional Staff and the detailed corresponding action will be agreed upon with several regional partners (with a vested interest in CH programming) during a validation workshop expected to take place in February 2022, which will serve as the basis for the development of the evaluation management response. *Each recommendation has been cross referenced and marked with the most relevant corresponding conclusions as are given in Chapter#4 under each DAC criteria* i.e., Relevance (REL), Effectiveness, (EFF), Efficiency (EFY), Sustainability (SUS) and cross cutting priorities gender equality (GE), equity (EQ) and HRBA (H).

A. Strategic (mostly aimed at UNICEF WCARO and its global/regional partners)

- **Integrate CH into national health sector plans** and, where needed, formulate/implement dedicated strategic plans for community health, while ensuring a multisectoral approach with Ministries of Finance, Decentralisation/Local Government, Social affairs, and Social Protection. [EFF#1, 2, 6, 10], [EFY#1&2], [GE#1, EQ#1], [SUS#1-3]
- **Focus CH policy, strategy, and implementation on the engagement with organised community groups** to mobilise support, cultivate ownership and involve communities to oversee the work of CHWs. To do so, it is crucial to enroot CH programmes and responsibilities within local governance mechanisms and reinforce social accountability of all actors. [EFF#10-13]
- **Advocate to both national governments and global partners** for dedicated and sufficient public financial allocations for CH programme scaling-up and implementation. [EFY#1-3]
- **Strengthen the institutionalisation of community health programmes** (in terms of technical, management and administrative aspects) and coordination capacities of relevant ministries (MoH/MoPH) at central, regional, district levels to ensure the nation-wide implementation of CH

approaches/interventions; and provide leadership and steerage to development partners through effective coordination. The actions may include:

- Assess the institutional/structural needs for CH planning and implementation at national and sub-national levels. To this end, set-up dedicated structures (and strengthen existing CH sections/units where available) with a clear definition of CH roles and responsibilities and to and a sound accountability framework. [EFF#10-13], [SUS#1-3], [H#1]
- Improve the design, implementation, performance, and evaluation of CH programmes through the application of the WHO guideline to optimize the performance and impact of community health workers. [REL#2], [EFF#6-10]
- Harmonize existing data collection tools and reporting formats for use by CHWS and supervisors and explore digitalization options for real time tracking and performance monitoring by using the Community Health Information System guidelines and linking it to Health Management Information system (HMIS). [REL#2], [EFF#6-9]
- Assess gender dimensions and undertake gender analyses to strengthen the planning of CH programmes that influence gender equality within the communities and promote female leadership and roles in the implementation of community health programmes. [EFF#6], [EFY#6-9], [SUS#1], [GE#1, H#1, EQ#1]

B. Operational (mostly aimed at the UNICEF Country Offices and their in-country partners across the region)

- Re-assess and develop consensus around CH integrated package of services with a focus on keeping proven community-based interventions such as integrated case management of the three main diseases and screening and management of acute malnutrition. [EFF#1-5], [EFY#4-5]
- Assess/pilot the integration of other interventions such as early childhood development using the nurturing care framework as an opportunity to, not only reduce child mortality and morbidity, but also to support the thrive agenda. [EFF#1-5], [EFY#4-5]
- At implementation level, undertake mapping of resources and needs; recruit and deploy required staff needed to lead/assist in CH interventions, including the establishment of national master list of geo-referenced CHWs as the very first step to official recognition (and endorsement) by the MoH the assessment of training and resource needs; the elaboration of capacity development plan/s with clear targets and actions; monitoring plans; and resources. [EFF#1-5]
- Support the pilot of digital data collection and use at decentralized levels
- Focus the CHWs performance evaluation and quality of care (identification/screening, diagnosis, treatment, and referrals). [EFF#6-9]
- Allocate 5-7% of CH resources for M&E functions and advocate for application of RBM principles and practices. [EFF#10-13]
- Build on this regional evaluation (including its lessons learned) to commission country-wide CH ‘rapid’ evaluations in the future.

Introduction

This report presents the findings, conclusions and recommendations of the regional evaluation covering the Community Health Programme (CHP) in Guinea-Bissau (GB) and the Community Health (CH) approaches/strategy in Chad and the Central African Republic (CAR). The learning potential of this evaluation is not limited to the three countries participating in the evaluation but rather extends to the whole region: 20 of the 24 countries in WCAR have a national CH programme and are likely to leverage on the lessons learned and good practices identified by this strategic exercise. This is all the more apparent as, despite the CH increasing visibility, its integration into national health systems is still rather weak. UNICEF commissioned this evaluation as it has been working quite closely with both national and regional institutions and partner organizations to enhance the access to quality health services by the most deprived children and families. In particular, UNICEF has provided focused CH support to governments in the three countries towards the reduction of maternal, neonatal, and child mortality. The Programmes' interventions are funded by varied partners in each country, such as the European Union (EU), UNFPA, the World Bank, the Bill & Melinda Gates Foundation (BMGF) and the Swiss Cooperation. The evaluation will help national governments and relevant ministries (particularly the Ministry of Public Health), implementation partners (IPs)[14], and development partners in the three countries to strengthen accountability framework (for duty bearers) for delivering integrated quality community health services for all population (particularly communities in low access areas and remote populations) by involving communities (community health worker, community-based groups, leaders and influencers) to save lives of children, and pregnant and lactating women as the right holders.

Besides informing the implementation of CH approaches across the region, the conclusions and recommendations of this evaluation will also provide a sound evidence basis to refine the theory of change related to the UNICEF's programming around community health as well as immunization strategies (also referred to as "KRC- 1", where KRC stands for Key Result for Children)[15] in the future. Moreover, the evaluation will shed light on some potential corrective actions to take in order to accelerate progress towards Sustainable Development Goals (SDGs), specifically goal 3.1 and 3.2, by 2030.

AAN Associates (hereinafter known as 'the evaluators'), a long-standing UNICEF contractor, was commissioned to undertake the multi-country evaluation. The Contract benefited from the support of the three UNICEF Country Offices as well as the UNICEF's Western and Central African Regional Office (WCARO). The evaluation chronological scope included all CH interventions implemented in the 3 countries between June 2015 and September 2019. The expected users of this evaluation include UNICEF Country Offices in the three countries, UNICEF Western and Central African Regional Office (WCARO) and related national governmental institutions with a vested interest in maternal and child health, implementing partners, and funders. The key objective of the evaluation was to assess the effectiveness and integration of CH approaches to inform the future strategies, policies, and operational approaches in this domain in the near future.

The evaluation was undertaken between February 2020 and December 2021. The evaluation team faced multiple constraints in the course of this assignment, including COVID-19 driven travel and assembly restrictions, as well as delays in acquisition not only of ethical and administrative approvals but also of secondary data. The overall evaluation approach and methods were adapted to overcome the limited mobility and the ban of people gatherings (e.g., focus group discussion, etc.). To this end, a series of mitigation strategies were implemented. These included expanding the national evaluation teams; bringing the new national consultants and partners up to speed on the evaluation; relying more widely on remote data collection; adding an additional layer of monitors for oversight, along with active engagement of the international team for quality assurance. The evaluation was undertaken as per the scope and methodology outlined in the evaluation Terms of Reference (ToRs), finalized in the inception phase, and approved by UNICEF (See Appendix 01).

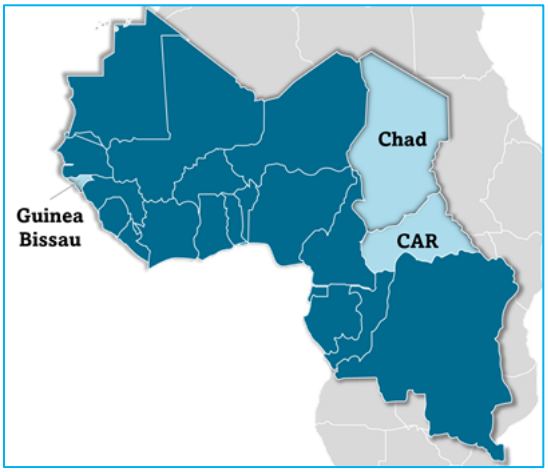
[14] Key IPs in GB have been Assistência Médica Internacional (AMI); Associazione Italiana Amici di Raoul Follereau (AIFO); Médicos da Comunidade (MdC) or Doctors of the Community; and Volunteers for Inter- American Development Assistance (VIDA). In CAR, key IPs were Centre de Support en Santé Internationale (CSSI), Médecins d'Afrique (MDA), Jeunesse Unie pour la Protection de l'Environnement et le Développement Communautaire (JUPEDEC), and Association des Femmes Rurales de Batangafo pour le Developpement (AFRBD). In Chad, key IPs were the MENTOR Initiative, World Vision International, ASRADD, and Red Cross Chad amongst others.

[15] https://www.unicef.org/wca/media/6566/file/UNICEF%20KRC%209%20Toolkit%20.pdf

Chapter 1: Programme Introduction (Object of the Evaluation)

The following chapter presents the intervention context (administrative, socio-economic, and legal context around the health care services, specifically at the community level) and the Programme's object of evaluation in the three countries. Furthermore, the subsequent section argues on the overview of broader policies and administrative environment around the community health services and relate it in the light of the regional and global situation.

Figure 1.1: Location of three Countries



1.1. Background

This section provides a brief overview on demographics of each country included in the evaluation i.e., Guinea-Bissau, Chad, and Central African Republican. The Figure presents the geographic location of each country in the WCARO Region.

The description includes overview of the healthcare environment, illuminating mother and child healthcare needs that warranted the intervention.

Table 1.1: Key Facts of the Three Countries

	Guinea-Bissau	Chad	CAR
Population[16]	1.9 million	14.1 million	4.7 million
Capital	Bissau	N'Djamena	Bangui
Official Language	Portuguese	Arabic and French	French
Religious Composition[17]	Muslims (50%) Christians (10%) Indigenous religion (40%)	Muslims (55.3%) Christians (40.6%)	Christianity (89.5%) Muslims (8.5%) Indigenous religion (2%)
Poverty Rate	69.3	47%	71%
HDI Ranking[18]	178	187	188

Guinea-Bissau is a West African country bordering Senegal and Guinea with a population of about 1.9 million[19] and an area of 36,125 sq. km[20]. The country is divided into 9 administrative units[21] (as shown in Figure 1.1) with Portuguese as official language, spoken by 14% of the population while French is spoken widely and taught as a second language throughout the country.[22] It is predominantly a Muslim country (about 50%).[23]

Figure 1.2: Map of Guinea Bissau

Guinea-Bissau is one of the most coup-prone and politically unstable countries in the world.[24] In 2019, Guinea-Bissau ranked 178th position out of 189

[16] https://worldpopulationreview.com/countries
[17] https://worldpopulationreview.com/countries/
[18] http://hdr.undp.org/en/content/latest-human-development-index-ranking; out of total 189 countries
[19] http://data.un.org/en/iso/gw.html; accessed on July 15, 2020.
[20] https://www.worldometers.info/world-population/guinea-bissau-population/
[21] https://www.britannica.com/place/Guinea-Bissau
[22] https://www.worldatlas.com/articles/what-languages-are-spoken-in-guinea-bissau.html
[23] https://worldpopulationreview.com/countries/guinea-bissau-population/
[24] https://www.bbc.com/news/world-africa-13443186

countries[25] on Human Development Index (HDI). Furthermore, in 2020, two out of three individuals in the country live under conditions of absolute poverty[26] placing it among one of the world's poorest countries. Guinea-Bissau faces several socio-economic issues such as poor infrastructure, low literacy rate (48%) and several health issues including deadly malaria, bacterial and protozoal diarrhoea, and others.[27]

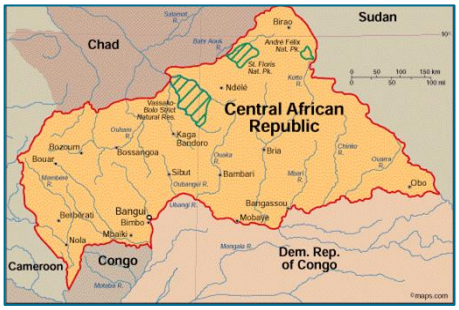
Chad: The Republic of Chad is the fifth-largest country in Africa bordered by Libya, Sudan, Central African Republic (CAR), Niger, Nigeria, and Cameroon with a population of 14.1 million and an area of 1,284,000 square kilometres. It has 23 regions[28] (as shown in Figure 1.2) while Arabic and French are the official languages and.[29] The major religion is 'Islam' with 55.3% Muslims.[30] Since independence in 1960, Chad's history has been marked by instability and violence, stemming mostly from tensions between Arab-Muslim in the north and the predominantly Christian and animist in the south.[31] Chad currently hosts 11,000 of the 117,000 Central African refugees who also fled their country in the wake of post-electoral violence.[32]

Figure 1.3: Map of Chad

Despite the implementation of various development strategies, Chad is one of the poorest countries in the world with 47%[33] of its population living below the poverty line, Human Development Index of 0.401 with a ranking of 187 out of 188 countries (2019).[34] The current health expenditure of Chad per capita (US$) was $29.73 in 2017 i.e., 4.49 % of GDP spending on health.[35] Chad faces several socio-economic issues such as poor infrastructure[36], low literacy rate (22.3%) and several health issues including epidemics (meningitis, measles, cholera, etc.), other communicable and non-communicable diseases and maternal illness.[37]

Central African Republic (CAR): is a landlocked country bordering Chad, Sudan, the Democratic Republic of Congo, and Cameroon.[38] It has a population of about 4.7 million[39] and an area of 623,000 sq. km. French is the official language[40] and Christianity is the predominant (89.5%) religion.[41] Bangui is the capital city of CAR, and the country is divided into **17 prefectures**[42] (as shown in Figure 1.3). Since its independence in 1960, CAR experienced decades of violence and instability resulting in a weak economy. The poverty rate is among the highest in the world with 71% of population living below the international poverty line[43]. The poor socio-economic conditions of the population are compounded by low literacy at 37.4% placing the Country at 188 out of 189 countries/territories on the human development index.[44] This unstable political and weak economic situation resulted in a

Figure 1.4: Map of CAR



[25] http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/GNB.pdf
[26] WFP Guinea Bissau Country Brief (January 2020); https://docs.wfp.org/api/documents/WFP-0000113145/download/?_ga=2.4678842.828672666.1597144957-1670909559.1597144957
[27] https://www.africaw.com/major-problems-facing-guinea-bissau-today
[28] National Health Development Plan, 2018-2021
[29] https://www.worldatlas.com/articles/what-languages-are-spoken-in-chad.html
[30] http://www.globalreligiousfutures.org/countries/chad/religious_restrictions#/?region_name=All%20Countries&restrictions_year=2016
[31] https://www.bbc.com/news/world-africa-13164686
[32] https://www.unhcr.org/news/briefing/2021/4/607e888f4/refugees-arrive-chad-following-recent-clashes-car.html
[33] United Nations Development Programme and Oxford Poverty and Human Development Index, *'Global Multidimensional Poverty Index 2019*: Illuminating inequalities', UNDP and OPHDI, 2018.
[34] United Nations Development Programme 2019. *Human Development Report Office 2019: 2019 Human Development Index Ranking,* retrieved from: http://hdr.undp.org/en/content/2019-human-development-index-ranking
[35] https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=TD
[36] National Health Development Plan, 2018-2021
[37] National Health Policy, 2016-2030
[38] https://worldpopulationreview.com/countries/central-african-republic-population/
[39] World Bank database (2018)
[40] Programme Document (Analysis of the Situation of Children's Rights in the Central African Republic 2015). (Population of capital (2014).
[41] The Future of World Religions: Population Growth Projections, 2010-2050; http://www.globalreligiousfutures.org
[42] https://reliefweb.int/sites/reliefweb.int/files/resources/acaps_country_profile_car_27july2015.pdf & https://documents.wfp.org/stellent/groups/public/documents/ena/wfp220378.pdf
[43] https://data.worldbank.org/country/central-african-republic
[44] http://hdr.undp.org/sites/default/files/Country-Profiles/CAF.pdf

humanitarian crisis that has worsened the health services particularly around mother and children's indicators in CAR.[45]

1.2. Intervention Context

This section captures the magnitude of the Maternal Mortality and U5 mortality at global, regional, and national level as well as rationalize the need for intervention. It also summarizes the existing regional and national frameworks in each country.

At a **Global level,** there were 295,000 maternal deaths in 2017 due to preventable causes related to pregnancy and childbirth of which 94% occurred in low and lower-middle income countries[46]. In 2018, around 5.3 million children under the age of 5 died globally, almost half during the first month[47]. Among the children under the age of 5 years, almost one-third of global deaths were due to preventable diseases like pneumonia (15%), diarrhoea (8%) and malaria (5%). Malnourished children, particularly those having severe acute malnutrition, are at a significantly higher risk of death from common childhood illnesses such as diarrhoea, pneumonia, and malaria while 45% deaths in children under 5 were due to nutrition-related factors[48].

At a **Regional level,** the Sub-Saharan African region had the highest maternal mortality ratio worldwide (i.e., 542 maternal deaths per 100,000 live births) in 2017, accounting for around 66% (196,000) of the global maternal deaths (295,000)[49]. In addition, the region also had the highest under-five mortality rate (78 deaths per 1,000 live births) in the world, accounting for more than 80% of the 5.3 million deaths in children U5 in 2018 along with Central and Southern Asia.[50]

At a **country level,** the situation on maternal and child health indicators is also adverse which is summarized below for each country.

Figure 1.5: Child Mortality

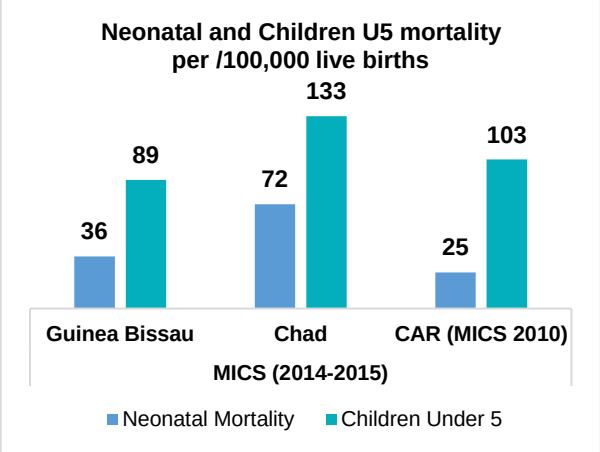
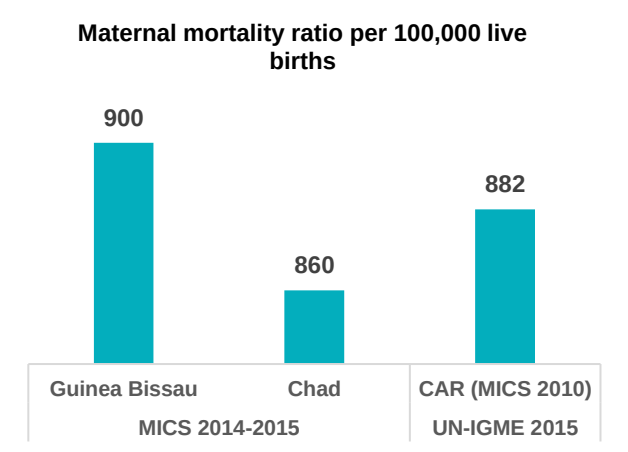


Figure 1.6: Maternal Mortality Ratio



[45] https://data.worldbank.org/country/central-african-republic
[46] Maternal Mortality: Levels and trends https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/
[47] https://www.unicef.org/health/maternal-newborn-and-child-survival
[48] https://www.who.int/en/news-room/fact-sheets/detail/children-reducing-mortality
[49] Maternal Mortality: Levels and trends https://www.who.int/reproductivehealth/publications/maternal-mortality-2000-2017/en/
[50] https://childmortality.org/wp-content/uploads/2019/10/UN-IGME-Child-Mortality-Report-2019.pdf; https://www.unicef.org/reports/levels-and-trends-child-mortality-report-2019

GB: Due to extreme poverty and underdevelopment, Guinea-Bissau has poor indicators for women's and children's health (as shown in Box 1), carrying one of the worst Maternal Mortality Ratio (MMR) in the world. Consequently, Guinea-Bissau has renewed its priorities and political commitment to maternal, new-born and child health in recent initiatives on National Health, Nutrition & WASH policies. These include the National Health Development Plans (NHDP II 2008-2017 & III for 2018-2022), Operational Plan to Scale up High Impact Intervention for the Reduction of Maternal and Child Mortality (POPEN 2010-2015), the Strategic Plan to fight Malaria, the Strategic Plan for Cholera 2009-2013, the Master Plan for Water and Sanitation 2010-2020 and the Strategic Framework and Investment Plan for Achieving the health MDGs[51]. Furthermore, the Government of Guinea-Bissau (GoGB) is a signatory to several international and regional conventions (CRC, Regional Compact) supporting child health.

Box 1: Maternal & Child Mortality Facts – Guinea Bissau

MMR: 900 deaths per 100,000 live births (MICS 2014)

Child (U5) Mortality CHAD: 89 deaths per 1000 live births (MICS 2014)

In GB, chronic malnutrition, malaria, measles, diarrhoea, respiratory and other infections are among the leading causes of deaths among Children U5 **(MICS 2014**).

The Community Health in GB was revitalized in 2010 with community health workers placed as the first point of contact for the promotion of the 16 Essential Family Practices (EFP). In the same year, the National Community Health policy (NCHP 2010) was developed to optimize community-based services and care for achieving universal access to health services. In 2015, Guinea-Bissau developed its national Community Health Strategic Plan (CHSP 2016-2020) for implementation of Integrated Community Case Management (iCCM) specifically for three main diseases (Pneumonia, Malaria, and Diarrhoea)[52] responsible for deaths among children under 5 years of age. The present strategic plan is being operationalized through several programs, mainly the EU-supported 'Integrated Programme for the Reduction of Maternal and Infant Mortality (PIMI)'[53]. The PIMI Programme as a whole adopted three key components: a) Delivery of quality health services; b) Reduction of financial barriers containing cost recovery and incentives scheme at the health facility level; c) The CH component coordinated by UNICEF.

Chad: Similar to the gloomy conditions in GB, the Maternal Mortality and U5 indicators are worse in Chad, as shown in Box 2. The main factors causing high maternal deaths include age at time of pregnancy, high frequency of pregnancies, low purchasing power, lack of accessibility of health centres, the status of women, as well as the lack of awareness of reproductive health[54]. In Chad, the legal framework to govern the health sector is insufficient but the Government of Chad (GoC) has renewed its priorities and political commitment to give primary importance to the health of the mother, new-born, and child in various strategic documents including the National Health Development Plans (NHDP II (2013-2015), NHDP III (2018-2021), the National Health Policy (NHP) (2016-2030) and the National Strategic Plan for implementing Universal Health Coverage (2017-2019) amongst others. Also, the GoC introduced legal measures[55] to make community participation effective in the implementation of health activities and to be aligned with its international commitments. To pursue the abovementioned national and other international commitments[56] the GoC developed its first National Community Health Strategic Plan (CHSP) in May 2015.

Box 2: Maternal & Child Mortality Facts – Chad

- MMR: **860 deaths** per 100,000 live births (DHS-MICS 2014-2015)

- Child (U5) Mortality CHAD: 65 deaths per 1,000 live births (DHS-MICS 2014-2015)

- **In Chad**, chronic malnutrition, malaria, measles, diarrhoea, respiratory and other infections are among the leading causes of deaths among Children U5.

[51] Programme document (iCCM- NATIONAL IMPLEMENTATION GUIDE)
[52] UNICEF Progress Report 1 (2018-2019); EU funded CHP in Guinea Bissau
[53] ToRs's – PIMI (Programa Integrado para a Redução da Mortalidade Materna e Infantil)
[54] National Health Development Plan, 2018-2021
[55] **Order 003/MSP/DG/94:** Established community participation in healthcare financing. 2) **Act 019/PR/99:** enabled the involvement of community in financings, planning, management, and evaluation of health services at all levels. 3) **Decree 364/PR/MSP/2001:** concerned organization of community participation in healthcare financing. (***Source:*** **ToRs)**
[56] Chad had endorsed to **Alma Ata's 1978 declaration** which advocate **"health for all by the year 2000"** and the **"Bamako initiative 1987"** which emphasize on community participation for planning and organizing health services for themselves.

CAR: The humanitarian crisis unfolding between 2012 and 2014 has deteriorated the already precarious health situation and the fragile health system in CAR, as reflected by country's performance on indicators related to maternal mortality and U5 mortality (refer to Box 3). The main causes of the high mortality and morbidity were the prevalence of infectious diseases, the poor access to quality health services, the limited access to health and sanitation service and, lastly, the poor knowledge and application of key family practices including infant feeding and young child. This is compounded by structural challenges, including inadequate and unequal distribution of health facilities, and low qualification of health personnel. Main causes of infant and U5 child mortality in CAR are Diarrhoeal diseases (24%), Malaria (22%), Pneumonia or acute respiratory infections (7%), neonatal infections, and malnutrition[57]. The aforementioned poor health situation is recorded despite the existence oof the National Health Policy and the National Health Development Plan 2006-2015, which proved to be quite ineffective. In response to the ongoing challenge, the country developed a Transition Plan 2014-2015 as a reference framework and guidance for health interventions[58]. Furthermore, on the legislative front, the Government of CAR became signatory to several international and regional conventions supporting child survival & health.

Box 3: Maternal & Child Mortality Facts – CAR

- MMR: **882 deaths** per 100,000 live births (MICS 2014)
- Child (U5) Mortality CHAD: **130 deaths** per 1000 live births (MICS 2014)
- 41% children U5 suffer from Chronic Malnutrition
- Malaria remains the leading cause (22%) of death
- 36% of all sick children receive proper care

Within the above context, UNICEF came forward to support the Government in fulfilling its commitment to 'reduce the high child mortality rates in the country' and to start implementing the 'community-based integrated management of childhood illnesses (C-IMCI)' at scale to improve access to treatment for children. This approach was originally based on the global IMCII strategy launched by WHO and UNICEF in 1995, to promote equity and to contribute to a sustainable reduction of child mortality[59]. In 2016, with support of UNICEF CAR CO and the European Union (EU), the Ministry of Health & Population (MoHP) launched this Programme which is part of this evaluation object.

1.3. Programme Overview: Object of Evaluation

This section provides an overview of the UNICEF's CH programme and approaches/strategies implemented in each one of the three countries covered by this evaluation. In doing so, it describes the Programme design, objectives, evolution, implementation, timeline, geographic scope, stakeholders and their roles, participants (beneficiaries) and resources.

Table 1.2: Summary of Programme Description (Object of Evaluation)

GB	Chad	CAR
The UNICEF-supported Community Health Programme (CHP) included all community-based health interventions under the national Community Health Strategic Plan (CHSP 2016-2020)[60]. The CHP aimed to 'contribute to accelerate the reduction of maternal, neonatal and infant mortality in Guinea-Bissau' and was implemented in 11 health	Multiple CH approaches and interventions were implemented as part of the national Community Health Strategic Plan 2015-2018 (CHSP). This included various pilot CH interventions by the government, UNICEF, and donors. This evaluation focused on UNICEF supported CH initiatives: CBVP[62], CFC-RTM, iCCM and the1000the 1000-days approach to the	The UNICEF-supported Community Health Programme (CHP) is the CH approach which was operationalized through a package of CH interventions namely 'Community-based integrated management of childhood illness in low access areas of CAR'. The Programme was implemented in six prefectures including 9 health districts; 107 referral health facilities linked with 193 functional community

[57] Ibid
[58] Programme Document (Health Sector Transition Plan 2015-2017)
[59] Child Mortality Report United Nations Children's Fund, 2015, Levels & Trends in Child Mortality, Estimates Developed by the UN Inter-agency Group for Child Mortality [Internet]. UNICEF, 2015.
Available: https://www.unicef.org/publications/files/Child_Mortality_Report_2015_Web_9_Sept_15.pdf; Gera T, Shah D, Garner P, et al Integrated management of childhood illness (IMCI) strategy for children under five. 10.1002/14651858.CD010123.pub2
[60] During inception, the UNICEF team shared that the program did not have funding for the HIV so not mentioned in scope.
[62] The acronyme in French is "Approche Communautaire pour la Promotion de la Vaccination" (ACPV)

Table 1.2: Summary of Programme Description (Object of Evaluation)

GB	Chad	CAR
regions of the country[61] from August 2017 to October 2019.	prevention of malnutrition through support groups. The other two interventions that are also part of this evaluation are Integrated package of interventions focused on immunization and Training of 1000 Community Health Workers (CHWs).	care sites (CCS) from November 2016 to May 2019.[63]

1.3.1 Goals & Expected Results of the Programme

This section stipulates the Programme's goal and expected Results in each of the three countries concerned by this evaluation.

Guinea-Bissau: The Programme Goal in Guinea-Bissau was *"to assist the government in accelerating the reduction of maternal, neonatal, and child mortality in all 11 regions of the country."* The programme had 5 result areas (see the table below).

Chad: The Community Health Strategic Plan (2015-2018) aims to *"contribute to the reduction of morbidity and mortality in Chad, with the effective participation of the people, accompanied by the health staff".* The Plan allows to operationalize the Community Health National Strategic Plan. It structured the process for development of health services in the community-based level.

CAR: The main objective of the Programme in CAR was *"to improve equitable access to essential care for children under 5 years to reduce morbidity and infant mortality".* The programme's specific approach was to ensure community management of childhood illnesses (malaria, diarrhoea, acute respiratory, infections, malnutrition) to ensure child survival, reduce morbidity, and promote growth and development in the six targeted prefectures. For details on expected results and key interventions in each country, refer to Appendix 02, 03 and 04.

Table 1.3: Expected Results and Key Interventions

Country	Result Areas / Interventions
GB	**Results Area 1:** The essential drugs, materials, and equipment necessary for CHW to continue the promotion, prevention and quality care are available at communities. **Results Area 2:** The 16 EFPs in the regions covered by the project are promoted and reinforced by the CHWs. **Results Area 3:** Improvement of quality nutrition services for pregnant and breastfeeding women, boys and girls at community level and health structures through advice on infant and young child nutrition, screening, and treatment malnutrition in children under five. **Results Area 4:** Coordination and management of health and nutrition activities for children of <5 years in the 11 regional health directorates and in the health, areas are reinforced. **Results Area 5:** The capacities of communities, households, and health centres to change behaviours around water, hygiene and sanitation are strengthened.
Chad	**Result 1:** Community-based health services, promotive, preventive, curative and quality are delivered by the trained CHWs in at least 80% of the target villages. **Result 2:** Leadership and community health management capabilities are strengthened at all levels of the health pyramids.
CAR	**Result 1:** Improving Community health worker performance at primary healthcare (PHC) level, which was subsequently expanded to the referral and community levels, **Result 2:** Strengthening health system performance and **Result 3:** Enhancing community and family practices (For details on 16 key family care practices, please refer to Appendix 05).

[61] ToRs
[63] ToRs

1.3.2 Geographic Spread

The following section covers Programme Regions in each country and the phases of implementation.

Table 1.4: Programme Coverage

Country	Result Areas / Interventions
GB	The first phase was implemented in 2017-2018 and covered five regions (Biombo, Cacheu, Oio, Farim and Gabu) whereas the second phase (August 2018 to October 2019) covered other six regions (Bafatá, Bijagós, Bolama, SAB, Quinara and Tombali).
Chad	All interventions comprised six different approaches which were implemented in different phases across various districts of the country. The Figure below captures the number of districts in which each approach under the Programme was implemented. For details on specific names of districts targeted, please refer to Appendix 06.
CAR	In Central African Republic, the Programme was implemented in 6 vulnerable prefectures i.e., Nana-Mambéré, Nana Gribizi, Ouham, Ouaka, Bamingui-Bangoran and Kemo[64].

Figure 1.7: Programme Coverage in CAR

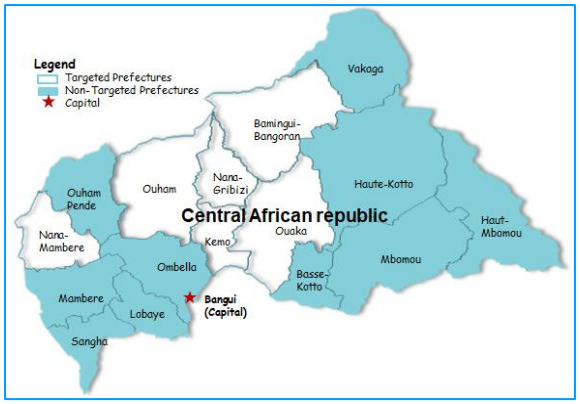


Figure 1.8: Programme Districts in Guinea-Bissau

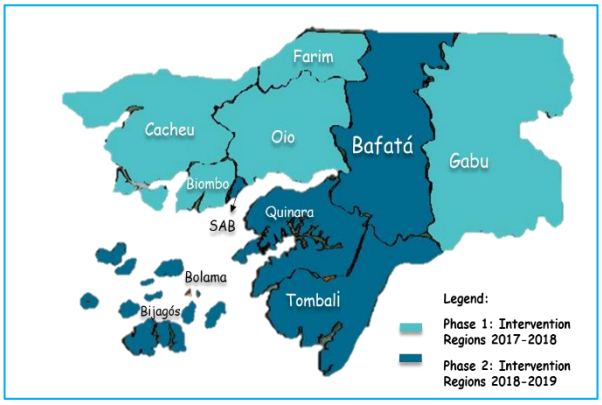
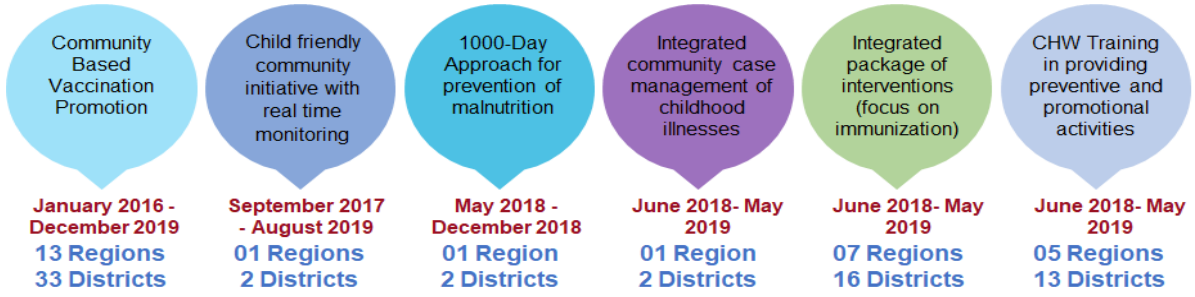


Figure 1.9: Coverage of CH Approaches/Strategies in Chad



1.3.3 Programme Stakeholders & Roles

A series of primary and secondary sector key stakeholders were involved in the design and implementation of the Programme in the three countries. These Stakeholders, along with their types and respected role in the Programme, are as follows:

Table 1.5: Programme Stakeholders

Stakeholder Name	Stakeholder Description & Role in Programme
Government (Primary Duty Bearers)	
Ministry of Public Health (MoPH), &	**Description:** Responsible for the overall policy formulation, planning, organization, and coordination of the health sector at national, province, district, and community levels.[65]

[64] Due to insecurity, Haute-Kotto was replaced with Kemo.

[65] https://www.developmentaid.org/#!/donors/view/145654/ministry-of-public-health-and-population-central-africanrepublic-ministere-de-la-sante-publique-et-

Table 1.5: Programme Stakeholders

Stakeholder Name	Stakeholder Description & Role in Programme		
	Role: MoHP participated in the formulation and validation of this programme. The various documents and guides developed by the project were validated by this ministry.		
UNICEF & Donor (Technical and Financial Partners)			
UNICEF	**Description:** UNICEF in each country supported the respective governments in promoting and protecting the rights of children. **Role:** UNICEF was responsible for the overall coordination of the Programme. UNICEF contracted and managed the IPs activities as well as collaborated with Regional Health Directorates to enhance their implementation capacity through various trainings and quarterly review meetings.		
European Union (EU) (The Donor)	**Description**: EU is a political & economical union of 27 member states, the world's leading donor of humanitarian aid, promote peace and well-being of the citizen. They offer freedom, security, and justice without internal border[66]. **Role:** Main donor for the Programme, as well as provided technical support through other funding arrangements.		
I/NGOs (Implementing Partners)			
Implementing Partners (IPs)	**Description:** All these are international and national non-governmental organizations involved in delivering social services. **Role:** All these IPs were responsible to lead the CH Programme implementation in their designated Prefectures. The Implementing partners were responsible to lead the CH Programme implementation in their designated Regions/Countries. All IPs share common roles such as training, deployment, and management of CHWs and coordination with health teams at health area level and with RHDs.		
	GB: PLAN International, VIDA, AMI, AIFO, MdC	**Chad:** The Mentor, World Vision International, ASRADD, Red Cross	**CAR:** CSSI, JUPEDEC, AFRBD, MDA, Caritas Bouar

For details on Implementing partners in each country and their role, refer to Appendix 07, 08 and 09.

1.3.4 Programme Participants

The principal groups whom the CH Programmes and interventions are expected to serve include pregnant and lactating women and their children under 5. Other key groups whose rights are expected to be realized by the CH interventions covered by this evaluation include a series of public sector entities and civil society actors who were directly and indirectly involved in the Programme implementation. These include:

- Public Sector entities such as MoHP at national, prefecture and district health level; and health facility staff.
- Service Providers: The Programme involved IPs who benefitted from the Programme in terms of capacity development.
- Community level actors: Parents/ care givers as health services users, and community-based organizations and community health workers who actively engaged in the training programs made available to them.

Table 1.6: Programme Participants (by type and country)

Countries	Beneficiaries		
	Children U5	**Pregnant Women**	**Women of Reproductive age (15 - 49 years)**
Guinea-Bissau	226,189	70,462	344,479
Chad	13,425,341	31,345	N/A*
CAR	81,197	N/A	N/A
*N/A refers to non-availability of specific numbers for the mentioned beneficiary categories.			

For more details on Beneficiaries in each country, refer to Appendix 10, 11 and 12.

[66] https://europa.eu/

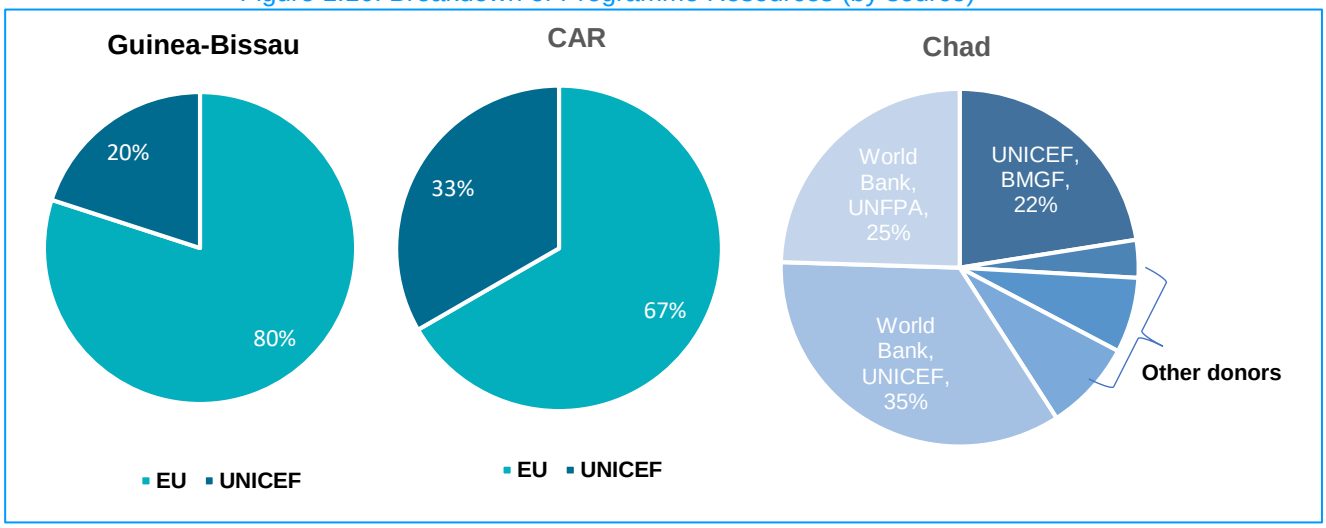
1.3.5 Programme Resources

The following section summarizes the funding and donor contribution for the CH Programmes and interventions in each one of the three countries. The total budget for programme in each country is represented in the table below whereas the pie charts represent the budget breakdown with respect to the donors in each country.

Table 1.7: Programme Resources (by country and source)

Guinea-Bissau	Chad	CAR
EU and UNICEF	UNICEF, UNFPA, the World Bank, Bill & Melinda Gates Foundation (BMGF), Swiss Cooperation, The Mentor	EU and UNICEF
€ 6 million	**$ 5.7 million**[67]	**€ 4.5 million**

Figure 1.10: Breakdown of Programme Resources (by source)



1.4. Significance of Community Health Programme

The description below outlines the Programme significance for all stakeholders at different levels.

Programme Significance for UNICEF: CH Programmes and interventions carry significance for UNICEF due to its alignment with UNICEF's global mandate to 'save children's lives, to defend their rights, and to help them fulfil their potential, from early childhood through adolescence'[68]. Also, the Programme is aligned with UNICEF's strategic objectives in these countries to support the respective governments in reducing mortality for mothers and children U5 by enhancing government's capacity for implementation of community health interventions.

Programme Significance for Government: CH Programmes and interventions are significant in that they contribute to saving the lives of mothers and children against deaths due to preventable causes. Below are more details for each country:

- **GB:** The CHP aligned with the GoGB health priorities, such as scaling up high impact interventions across the country and providing CH services to remote communities at their doorstep by establishing a network of CHWs.
- **Chad:** The CH strategies and interventions on the ground aimed to provide some references that could inform the Government's new CH policy in accordance with the country's health vision and development plans set out in the National Health Policy 2016-2030 and National Health Development Plan 2018- 2021.
- **CAR**: The CHP aligned with the Government of CAR's integrated management strategy of Childhood

[67] The evaluators have extracted all financial information from the available documents and consolidated it. Cumulatively all CH Interventions were implemented with about $ 5.7 million

[68] https://www.unicef.org/

Illness (IMCI) (2008), providing CH services to remote communities at their doorstep by establishing a network of CHWs and developing capacity to implementing CH without external support.

Programme Significance for Donor: In all three countries, the CH Programme and interventions hold significance for the EU as they: a) contribute to 'supporting the most vulnerable populations in terms of access to basic services and guaranteeing an inclusive socio-economic development'; and b) enhance the prioritization of humanitarian assistance in the three countries. Furthermore, the experiences accumulated, and the learning generated during the implementation of the CH programmes in these countries is likely to inform future investment decision on supporting governments for CH implementation.

Programme Significance for Communities: The CH Programme and interventions hold importance for the communities as they help save lives of mothers and children and contribute to their improved well-being. Also, they increase communities' awareness of preventive and curative aspects pertaining to mothers' and children's health issues. Moreover, such type of programmes and interventions provide basic health services in hard-to-reach areas and reduce health care costs.

1.5. Programme Theory of Change

In all three countries, the CH Programme and interventions were implemented without a documented Theory of Change (ToC). In the case of Chad, though, the review of programme documents indicated that a ToC existed at least at country level but only for Child Protection (and not for CH per se) activities. In order to address such gap, and as a way to guide the evaluation, a ToC was developed for all three countries based on the review of the relevant documents[69] as well as discussions with UNICEF staff. It is pertinent to underline that the three ToCs (referred to as "ex-post ToC") include, as is the case for all ToC, some inherent biases. The logic models developed based on the three ex-post ToCs (one for each country) are presented in Appendices 13, 14 and 15.

[69] UNICEF Country Programme Document (CPD 2016-2020), CHSP framework (2015-2018); CHSP framework (2015-2018)

Chapter 2: Evaluation Purpose, Objectives, Criteria and Scope

This chapter offers a brief overview of the evaluation purpose, objectives, criteria, key evaluation questions, scope, significance and the stakeholders, roles and uses. Given the fact that this is part of the regional evaluation, this chapter has followed a standard organization of the content for all the country reports.

Evaluation Purpose

The purpose of this evaluation is double fold: Organizational Learning and Accountability to both funders and groups who are expected to benefit from the CH interventions covered by this evaluation

Figure 2.1: Evaluation Purpose

<u>In order to fulfil the learning purpose,</u> this evaluation is expected to:

i. Identify areas of improvement (at design and implementation levels) for on-going and future CH interventions or Programmes.
ii. Gain an in-depth understanding of the progress, success factors and challenges to identify the possible areas for improvement in future CH programming; and
iii. Determine the extent and depth of coordination and collaboration for partnerships

<u>In order to fulfil the accountability purpose,</u> this evaluation is expected to:

iv. Gather evidence of Programme achievements vis-a-vis the planned targets, enabling, and disabling factors.
v. Assess the alignment and appropriateness of policies and guidelines for the CH Programme, as well as to determine the extent and depth of coordination and collaboration for partnerships[70]; and

More specifically, for **GB and Chad**, the evaluation has an expressed 'Formative'[71] focus. whereas in **CAR**, the evaluation has a summative focus[72].

2.1. Evaluation Objectives

The evaluation pursues the following objectives:

- To determine relevance, efficiency, effectiveness, sustainability and to the extent possible, the impact of the national CH strategic framework in the three countries.
- Identify lesson learnt about what worked and what did not, during the implementation of national CH strategic framework in the three countries, including unexpected outcomes (positive and negative).
- To assess the extent to which the CH services have integrated equity, human rights, and gender principles in their design, implementation, and monitoring.
- To assess to the largest extent possible, UNICEF's contribution to the CH strategic results (this required the reconstruction of a theory of change by evaluation team).
- To formulate key recommendations on how to improve the implementation processes and performance of different components of the strategic framework in the three countries.
- For the CAR and GB two additional objectives were fulfilled: (a) to identify the strengths and weaknesses of current interventions to understand their potentials or real contribution to the construction and consolidation of the health system in volatile context; (b) to provide evidence on the extent to which a package of CH integrated services a) has an added value in terms of strengthening the health system and reducing child morbidity and, where appropriate; and b) could be scaled-up.

[70] TORs
[71] The evaluation primary focus is on learning and Programme improvement, rather than accountability and demonstrating outcomes https://www.unicef.org/evaldatabase/files/UNICEF-MoRES_pubs-Annexes-web.pdf
[72] Summative evaluations are often implemented when a project or programme has ended, or is about to end, and it is no longer possible to make changes to that project or programme. https://www.intrac.org/wpcms/wp-content/uploads/2017/01/Types-of-Evaluation.pdf

2.2. Evaluation Criteria and Key Questions

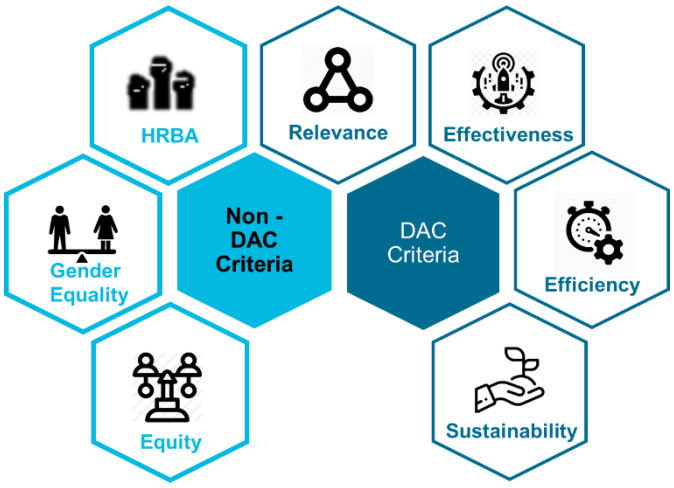
This section outlines the criteria and questions that guided the evaluation design and implementation.

2.2.1 Evaluation Criteria

The evaluation was guided by 5 criteria:

- four of the six standard OECD-DAC[73] criteria (**relevance, effectiveness, efficiency,** and **sustainability)**. The impact and coherence criteria were excluded (the impact criterion was not taken into consideration because of the difficulty in linking a decrease in infant and child mortality to a bundle of activities and approaches not always well codified at the country level; the coherence criterion did not yet exist at the time the evaluation ToRs were developed; and

Figure 2.2: Evaluation Criteria



One additional criterion pertaining to **gender equality, equity, and human rights-based programming,** referred to as non-DAC criteria.

2.2.2 Key Evaluation Questions

The evaluation questions as outlined in the ToRs were reviewed and key questions were rephrased as part of the scoping exercise undertaken during the inception phase. Keeping in view the evaluation expectations, the Evaluation Matrix (EM) was adapted for each country and is available for review as Appendix 16. The country stakeholders and UNICEF WCARO helped finalize the different evaluation matrices developed by the evaluation to guide the overall exercise. The final list of key evaluation questions (by criterion), as spelled out in the EM, are as follows:

Table 2.1: Evaluation Criteria and Key Evaluation Questions

Relevance
EQ1. To what extent did the objectives, strategies, and interventions of the CH Programme, approaches and initiatives align to objectives, strategies, and interventions of national health/CH policies, strategies and plans of each of the (Country name)? How did these relate to community needs and global CH Programming guidelines?
Effectiveness
EQ2. To what extent did the CH approaches and initiatives achieve their own objectives and by extension contribute to national plans/policy objectives in (Country name)? How internal and external factors either enabled or hindered the achievements? **EQ3.** To what extent did Programme manage to effectively identify and address the systemic gaps in different elements of national CH Programme, or approaches/strategies? How different internal and external factors either enabled or hindered the achievements? **EQ4.** To what extent did Programme leverage partnerships to achieve results?
Efficiency
EQ5. To what extent Programme resources – financial, human, and supplies were sufficient (quantity), adequate (quality) and distributed/deployed in time vis-à-vis planned results? Could same results be produced with alternative strategies at lesser costs?
Sustainability
EQ6. To what extent did Programme remain successful in designing and implementing strategies for sustainability and replication vis-à-vis governments, other partners, and communities?
Gender Equality, HRBA and Equity
EQ7. To what extent did Programme design and implementation integrate principles of gender equality, human rights, and equity?

[73] https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

2.3. Evaluation Scope

This section below provides an overview of the evaluation scope structured in terms of a) chronological scope, b) geographical scope, and c) thematic scope. The scope remains unchanged compared to what was initially outlined in the ToRs.

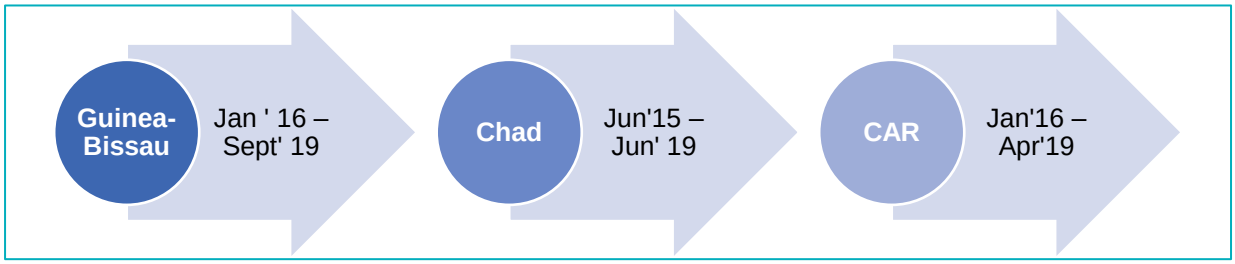
Thematic Scope:

1. **GB:** The evaluation covered the entire list of community-based health interventions outlined in the National CH Strategic Plan (CHSP 2016-2019). In particular, the evaluation focused on the UNICEF-supported CH interventions falling under the PIMI-II - the national Programme that operationalizes the CH Strategic Plan. For the sake of precision, such Plan primarily focuses on maternal, new-born and child health (MNCH). The evaluation took note of all evident changes in access to and use of the services by vulnerable women and children in areas of health, nutrition, and WASH[74].
2. **Chad:** The evaluation focused on all CH initiatives implemented under National CH Strategic Plan (CHSP 2015-2018) including various experiences and pilot interventions undertaken by the government, donors and implementing partners countrywide, such as Global Fund/UNDP, Swiss Cooperation, World Bank/UNFPA etc. In addition, the evaluation focused on the UNICEF-supported CH initiatives implemented as part of the CHSP
3. **CAR:** The evaluation focused on the EU-funded Project which implemented community-based health and nutrition interventions which include pneumonia, diarrhoea, malaria, neonatal infections, and malnutrition including screening, referral and monitoring of care and HIV. Also, the evaluation focused on to investigate the potential for cross- sectoral integration to assess the linkages and intersections of the different interventions.

Geographical Scope:

1. **GB:** While the document review included all 11 Health Regions where UNICEF-supported CH interventions under PIMI-II Programme were implemented, primary data collection was undertaken in only 7 regions i.e., Bissau, Biombo, Gabu, Quinara, Tombali, Oio and Cacheu.
2. **Chad:** While the document review focused on the CH interventions implemented nationwide, the data collection concentrated on some specific and more structured community- based interventions undertaken by the MoPH with support from UNICEF CCO and other partners in a few targeted regions._The primary data collection was undertaken in seven (out of total 23) Regional Health Delegations (Guera, Hadjer Lamis, Logone Occidental, Logone Oriental, Moyen Chari, Batha, and Mandoul).
3. **CAR:** The evaluation focused on the 6 prefectures (including Ouaka, Ouham, Kemo) that have implemented C-IMCI interventions, out of a total of 16 prefectures nationwide.

Chronological Scope:
ON average, the evaluation includes all relevant CH activities implemented in the three countries between January 2016 and June 2019.



2.4. Evaluation Stakeholders, Role, Interest and Uses of Evaluation

Find below the list of the different evaluation stakeholders and their corresponding role, interest, and possible uses of the evaluation. The ToRs and discussions with stakeholders have informed this section.

[74] While reviewing the draft IR, the UNICEF Programme focal person highlighted that the program did not have funding for the HIV component so not mentioned in scope.

Table 2.2: Evaluation Stakeholder Roles, Interest and Uses

Stakeholder	Role, Interest and Uses
Duty Bearers / Service Providers (Public Sector)	
Ministry of Public Health	**Interests:** Specifically, to know the key successes, challenges and institutional needs to continue CH implementation and handover to Government. **Uses:** To inform the revision of the national CH strategies and strategic plans and decisions on CH investments, future engagement with UNICEF for potential handover to respective governments in each country.
Implementing Partners[75] (I/NGOs)	
Implementing Partners	**Interests:** To understand the effectiveness, efficiency, and sustainability aspects of the implementation. To get an independent view on key successes, lessons, and key recommendations to improve future implementation for even better results. **Uses:** To adopt key lessons, good practices, and recommendations in their future implementation for optimization of resources and results. **List of IPs by country:** **GB:** Plan International, VIDA, AMI, AIFO, MdC[76] **Chad:** MENTOR Initiative, Red Cross Chad, WHO, World Vision International, CSSSI, Action Against Hunger **CAR:** CSSI, Cartias Bouar, MDA, JUPEDEC, AFRBD, CBOs (Women's groups)
Technical and Financial Partners (UN Agencies / DONOR)	
UNICEF Country Office	**Interest:** Analyse efficiency, effectiveness, and sustainability of NGO led implementation and continuing supporting governments of each country in institutionalization. **GB:** To extract lessons to redefine CH investments in the new CPD development. **Chad:** The Health section in the UNICEF CO intends to a) support advocacy for a more inclusive CH policy; b) focus CH interventions considering the evaluation findings; and c) understand how the community approach can drive a dynamic in achieving key results for children. **CAR:** To support advocacy for a more inclusive and CH policy and refocus CH interventions considering the evaluation findings.
Donors	**Interest:** To have evidence on donor contributions in strengthening the CH strategies, implementation, institutionalization, and hand over to respective governments; and to see how CH investments in specific country are contributing to achieving strategic objectives of donors. **Uses**: To review future relationships with government, UNICEF and other partners and decision on future investments on CH in three countries. **GB:** EU; **Chad:** GAVI, BMGF, KfW, Development Bank, SAAPRSD, EU, UNICEF, World bank, SIDA[77]; **CAR:** EU
UNICEF Regional Office (RO) (WCARO)	**Interests:** To adapt regional policy and strategic framework towards the institutionalization of CH approaches/strategies and to better respond to the country needs. **Uses:** To better support Governments in each country towards institutionalization of CH approaches/strategies; and to disseminate good practices and lessons learned with other regions.
Right Holders (Direct Expected Beneficiaries)	
Pregnant, lactating women & Children (U5)	**Interest:** To know how their access to and quality of CH services may be increased. **Uses:** To know more about the availability and benefits of existing CH services and the opportunities for them to participate in the community-based health services.

2.5. Evaluation Significance

The description below illuminates the significance for different stakeholders separately.

- **Ministry of Health/ Government:** The evaluation helped the Ministry of Health (MoH) in each one of the three countries to assess the results of its CH Programmes and interventions. MoH can now

[76] VIDA (Volunteers for Inter- American Development Assistance); AMI (Assistência Médica Internacional); AIFO (Associazione Italiana Amici di Raoul Follereau); MdC (Médicos da Comunidade - or Doctors of the Community)
[77] Global Alliance for Vaccines and Immunization (GAVI), Bill & Melinda Gates Foundation (BMGF), KfW Development Bank, UNICEF, Swiss Cooperation Development Department, Sahelian Alliance for Applied Research for Sustainable Development (SAAPRSD), World Bank, Canadian International Development Agency (CIDA), Swedish International Development Cooperation Agency (SIDA)

incorporate lessons learnt and good practices into the development of new national CH policy and use documented good practices as the basis for the design of future similar interventions.

- **UNICEF CO:** No external independent evaluation was ever conducted since the start of the Programme. Therefore, this evaluation is expected to assist UNICEF in refocusing its CH interventions/approaches based on the collected evidence. Furthermore, the evaluation provides stakeholders with a rigorous, rubric-driven, and independent assessment of Programme design, implementation approaches, achievements, and challenges.
- **UNICEF Regional Office:** The evaluation contributed to extracting challenges and lessons learned common to all three countries that could be of applicability to all the other CO in WCAR.
- **Donors:** The evaluation gives an independent view on how the funds have been used and the value it created for the children and families in each country. Moreover, it informs the donors about the country's needs and aims to guide donors' country and sector assistance strategies and priorities in the future
- **Communities:** The evaluation gave an opportunity to communities to share experiences and reflections on what changes (if any) the Programme has brought to their lives. Moreover, the evaluation yields suggestions from communities to help improve the Programme and meet community expectations/needs.

Chapter 3: Evaluation Design, Methodology, Quality and Ethics

This chapter describes the evaluation design, methodology, field data collection & quality assurance mechanisms (whilst undertaking COVID 19 precautions), compliance with UNEG/UNICEF[78] norms and standards for evaluations, evaluation limitations and mitigative actions.

3.1. Conceptual Framework and Evaluation Design

The evaluators used the Community Health Worker (CHW) Performance Improvement and Assessment Matrix (CHW AIM) developed by WHO[79] as well as other existing WHO guidelines[80] on CH Programme, as the framework informing the overall evaluation design. The Appendix 17 describes the conceptual framework for this evaluation more in detail and provides additional information on the CHW AIM matrix for each one of the three countries being evaluated. Furthermore, the evaluators used a **hybrid design** combining the 'Non-Experimental'[81] research design (i.e., '**Single Group Pre- and Post-Test')** with the so-called '**Contribution Analysis (CA)**' design; whereby the delivery of expected results and outcomes were tracked for the intervention group only[82]**.** This involved gathering data from one group and comparing results 'before and after the intervention'[83]**.**

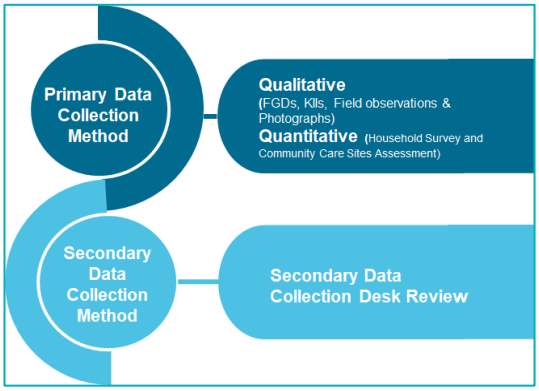
The Appendix 18 provides details on design considerations and key features and application of CA in the three countries.

3.2. Data Collection Methods

The evaluation relied on the **Mixed Method**[84]' approach for data collection. The overall methodology (See Figure 3.1) comprised the following methods:

1) Desk Review
2) Quantitative Methods: Household Survey (HHs)
3) Qualitative Methods i.e., Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), Workshops (Reflection & Findings Validation), Collection of Field Evidence/ Photographs

Figure 3.1: Data Collection Methods



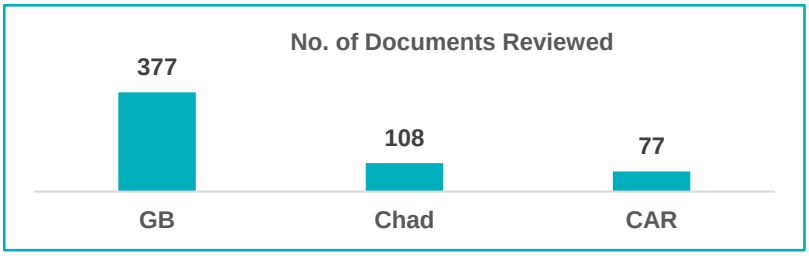
As the execution of all data collection methods was done during the COVID-19 outbreak, the Evaluators needed to integrate technology solutions (Zoom/Skype, Microsoft live translation and others etc.) into their (occasionally remote) data collection (where it was required). All surveys, FGDs and Regional level KIIs were conducted on-site by national experts and staff while complying with all COVID-19 safety measures and protocols (more details in section 3.5.2).

3.2.1 Desk Review

The Evaluation team reviewed **562 documents** (including programme documents and other key external documents)[85] shared by UNICEF staff, both in CO and RO. The desk review enabled the evaluation team's better understanding of the context, strategies, implementation approaches, challenges, and achievements of the CH Programme and interventions in the three countries under evaluation. The Appendices 19, 20, and 21 provide a 'summary table' and 'complete list' of all documents reviewed for each country during this evaluation. The figure above shows number of documents reviewed for each country:

[78] https://www.unicef.org/supply/files/ATTACHMENT_IV UNICEF_Procedure_for_Ethical_Standards.PDF;
[79] Functionality Matrix for Optimizing Community Health Programs (2018); https://www.unicef.org/media/58176/file
[80] WHO guideline on health policy and system support to optimize community health worker programmes 2018; https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf?ua=1&ua=1
[81] http://toolkit.pellinstitute.org/evaluation-guide/plan-budget/choose-an-evaluation-design
[82] AmeriCorps: https://www.nationalservice.gov/sites/default/files/resource/Evaluation_Designs_Slides.pdf
[83] https://www.go2itech.org/wp-content/uploads/2017/07/Evaluation-Design-and-Methods.pdf
[84] **Mixed methods** involve collection and analysis of both quantitative and qualitative data within the same study.
[85] Such as Country Programme Document, National Health Development Plan, UNDP Human development reports, country and region based Annual Reports, strategic plans for poverty reduction, Child Mortality estimation report and others.

Figure 3.2: Scope of Desk Review (by country)



3.2.2 Quantitative Data Collection

The evaluation methodology included a Household Survey (HHS) to analyse the Knowledge, Practices, and Coverage (KPC) of community health services[86]. The description below highlights some key aspects of the Household Survey (HHS).

Knowledge, Practices and Coverage (KPC) Survey

For quantitative data collection, a questionnaire-based HHS was conducted to quantify[87] and understand the precise level of knowledge, practices, and coverage of community health services for pregnant and lactating women (pre- and post-natal practices, child illnesses like diarrhoea, malaria, and pneumonia). The survey results were used to triangulate the qualitative findings as well as the secondary information in order to make valid judgments on the effectiveness of community-based health interventions. The primary **sampling unit** for this survey was 'Household' from which a mother with at least a one child (under five) was interviewed. In total, 400 eligible mothers were interviewed in each country (sample size was calculated statistically at 95% Confidence level, and 5% margin of error and applying 4.2% increase to overcome any methodological error or biases).

Table 2.3: Household Survey Sample Coverage (by country)

Country	Regions/Prefectures Sampled	Enumeration areas / Communities	No. of Households surveyed
GB	7	14	400
Chad	7	15	400
CAR	5	19	400

The field teams used the 'random walk selection' method, for the selection of the households to include in the sample and to identify the mothers eligible to be interviewed. The surveys were administered by deploying trained local female enumerators managed by the national partner in each country. More details on sampling frame, rationale, and method used for the selection of household and identification respondents are provided in the Appendix 22; likewise, the questionnaire used for survey administration is available for consultation in Appendix 23. Moreover, in addition to the household survey, direct observations were conducted in 10 Community Care Sites (CCS) in CAR by using a semi-structured checklist. The Appendix 24 and 25 provides details of the CCS assessment.

3.2.3 Qualitative Data Collection

The qualitative methods comprised Key Informant Interviews (KIIs), Focus Group Discussion (FGDs) with the beneficiaries, and Reflection Workshop with Programme planners and implementers. Overall, such methods, allowed exploring some variables of interest in order to better understanding some CH dynamics and processes yet unknown to IPs and funding partners. The number of KIIs and FGDs conducted in the three countries are presented in Figure below:

Key Informant Interviews (KIIs)

A total of **84** KIIs were conducted (36 in GB, 23 in Chad and 25 in CAR) with various stakeholders from Governments, UNICEF, Implementing Partners, Donors etc. The figure below shows the breakdown by stakeholder in each country. The KIIs were used to draw in-depth understanding of the views of

[86] https://www.snapsurveys.com/blog/qualitative-vs-quantitative-research/

[87] Quantitative methods are preferred to collect scientific, objective, fast, focused, and acceptable data to explain the variables under study. It is used to quantify attitudes, opinions, behaviours, and other defined variables as well as to generalize results from a larger sample population. https://www.snapsurveys.com/blog/qualitative-vs-quantitative-research/;

participants on CH design, implementation, achievements, challenges, lesson learnt and scalability. The questions in the KIIs guides (Appendix 26) were based on and linked with those included in the EM that guided the whole evaluation. The Appendix 27 provides list of all KII respondents.

Figure 3.3: KIIs Distribution (by country)

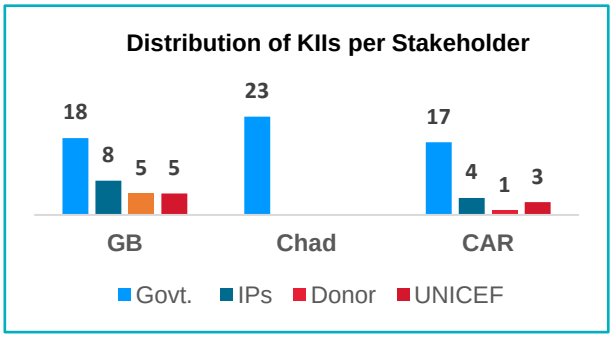
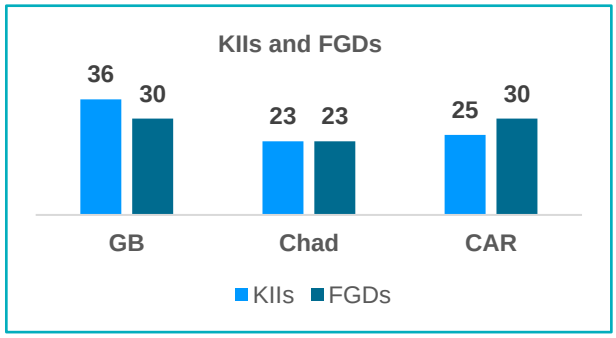


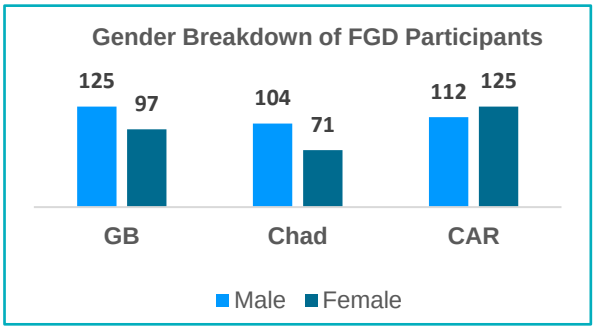
Figure 3.4: # of Number of KIIs and FGDs (by



Focus Group Discussion (FGDs)

Overall, a total of **83** FGDs were conducted in the three countries. The FGDs findings (when triangulated with survey results as well as with the KIIs and desk review finding) helped the evaluators to better understand, contextualize and nuance the opinions and perceptions of communities regarding their knowledge, health seeking practices, challenges, and experiences of the available CH services. The FGDs guides are provided in Appendix 28. For a detailed list of the participants of FGD in each country, please refer to Appendix 29.

Figure 3.5: Evaluation Participants by Sex



Field Observations (Photographs)

Field teams involved in data collection took field photographs to create evidence on the state of community infrastructures and working conditions amongst CHWs and health staff. These observations contributed to enhance the richness of the triangulation amongst survey, KII, and FGDs findings (refer to Appendix 29 for field evidence).

Stakeholders Workshops (Reflection & Presentation of Findings Validation)

Half-day long online reflection workshops with key stakeholders (public officials, IPs/NGOs, and UNICEF) were convened in each country to take their collective insights on key achievements, challenges, lessons, and recommendations as emerged during the real-time analysis of the data collected in the field (See Appendix 31 for agenda and participants' list). In addition, on completion of data analysis, the evaluators presented preliminary findings (validation workshops) to the key ERG members in each country. The feedback enabled evaluators to make factual corrections and refine the findings, conclusion, and recommendations.

3.3. Data Processing and Analysis

Quantitative data was first checked for its completeness, and correctness before being cleaned by a statistical expert and processed further for analysis by SPSS and Excel based tools (See Appendix 32 for HHS data analysis plan). For **qualitative** data analysis, a systematic process was followed which started by making transcriptions, translations followed by cleaning the transcriptions. Data was then entered, coded into MAXQDA (Appendix 33 for coding schema for qualitative analysis), extracted and summarized into themes to analyse and synthesize broader trends around key evaluation questions or indicators. The triangulation of quantitative and qualitative data helped the evaluators to analyse the 'contributions'[88] of the Programme and to highlight any unusual cases of positive or negative deviance, while considering the context and operational constraints.

[88] https://www.christianaid.org.uk/sites/default/files/2017-10/kenya-contribution-analysis-methods-guide-research-oct2015.pdf

3.4. Integration of Gender Equality, HRBA and Equity in Evaluation

This evaluation benefitted from and adhered to all applicable principles as prescribed in the UN Women publication on 'Good Practices in Gender Responsive Evaluation (May 2020)'[89], the United Nations System-wide Action Plan (UN-SWAP 2.0, 2018) on Gender Equality and the Empowerment of Women (GEEW)[90], and 'The UNEG Handbook on Integrating Human Rights and Gender Equality in Evaluation'[91]. Eventually, the gender perspective was considered and integrated into the evaluation design (evaluation matrix, methods), tools preparation, data collection protocols, data analysis and reporting as shown in the matrix below:

Table 3.1: Integration of Gender Equality, Equity and Human Rights into Evaluation

Evaluation Stage/Phase	Measures Taken for Compliance
Design level	• The EM included a separate section to include specific questions, sub-questions, and indicators on GE, HRBA and Equity. • The selection of evaluation methods ensured inclusion or participation of duty bearers, and right holders (male/female, rural/urban, literate/illiterate etc.) • Stakeholders (Govt, UNICEF, IPs as duty bearers, right holders) specific guides and methods (KIIs, FGDs and survey) were developed and applied. • Appropriate capacity building of all evaluation team members was ensured.
Implementation level	• Gender balanced teams were deployed for data collection. In sensitive areas, only female staff was deployed to demonstrate respect to cultural norms. • To ensure that perspectives of all relevant stakeholders be included, the evaluators reached 687 participants (78% female) in GB, 597 participants (79% female) in Chad and 662 participants (80% Female) in CAR. • As part of the HHS, 400 mothers in each country were interviewed in order for their reflections to be included in the evaluation. • Women's participation in FGD was significant: in **GB:** Out of 258 participants; 44% were female); in **Chad:** of the 175 participants; 41% were female; and **CAR:** over a total 175 participants; 41% were female) • For FGDs, sperate discussions were conducted with mothers and fathers. • For equity integration, rural communities were included in the survey sample so that their perspectives be adequately represented in this evaluation. In **GB, 64%** respondents were from rural communities); in **Chad, 43%** respondents were from rural communities); in **CAR**, all survey respondents were from rural communities.
Analysis and Reporting	• All data was disaggregated by parameters of GE, HRBA and equity. • Distinct coding for GE, HRBA and Equity was implemented to extract themes. • The synthesis of evaluation findings, conclusion and recommendations was informed by all the key considerations above.

3.5. Quality Assurance of the Data Collection

The Evaluators applied the following approach for quality assurance:

3.5.1 Field Staff Training, Pre-testing, and quality assurance of data collection

The core evaluation team provided all national consultants with a comprehensive three-day online training (20th to 22nd October 2020) followed by a refresher training aimed at both the national consultants and national partner' staff including the survey manager, moderators for KIIs/FGDs, field supervisors, and data manager. Post training, the HHS questionnaire was pre-tested by interviewing 25 households in a community in each country. The collected data was processed and analysed and the HHs questionnaire was modified based on the enumerators' feedback and analysis of the data.

The evaluation team maintained strict quality assurance field protocols. Key implemented measures included deployment of field supervisors (accompanying interviews, on-spot checking), dedicated QA staff (random spot-checks, 10% back checks), gender balanced teams, ensuring voice recordings of

[89] https://www.unwomen.org/en/digital-library/publications/2020/06/good-practices-in-gender-responsive-evaluations
[90] https://www.shareweb.ch/site/Multilateral-Institutions/Documents/UN%20SWAP%20Gender%20Equality%20Brochure.pdf
[91] http://www.uneval.org/document/download/1294 (2011); Integrating Human Rights and Gender Equality in Evaluations: UNEG Guidance Document August 2014) http://www.unevaluation.org/document/download/2107;

KIIs/FGDs, and maintaining close coordination and communication among all field staff (Appendix 34 offers more details on all quality assurance protocols implemented in field).

3.5.2 Safety and Protective Protocols implemented under COVID-19 Situation

In addition to general quality control measures, the evaluators implemented various safety and protective protocols (Appendix 35) to ensure that all evaluation participants/respondents and them evaluators themselves not be exposed to any possible risk of COVID-19 infection. Key measures included a) maintaining safe distance; b) avoiding physical contact; c) covering face at all times with masks; d) carrying and using sanitizer during field work.

3.5.3 Ethical Approval

The field work was initiated only after ethical approval was obtained in each one of the three countries. As part of the process, the evaluators presented the inception report to the evaluation steering committee (as part of the ERG). The UNICEF team in each country supported the evaluators in attaining the approval.

3.6. Compliance to UNEG/UNICEF Adopted Norms and Ethics

The evaluation complied not only with the United Nations Evaluation Group (UNEG) ethical and evaluation standards[92] – but also with the UNICEF adapted norms and standards[93]. A series of quality assurance mechanisms (extensive training of all field teams, pilot-testing of tools, spot-checks during data collection and others) were evolved and applied for quality and consistent data collection. Keeping in view the COVID 19 realities, the evaluators applied safety and security protocols for fieldwork. Before initiating the data collection, the required ethical approval was secured in GB and Chad. For CAR, an ethical endorsement was provided by the line ministry which is an integral member of the Evaluation Reference Group.

The Appendices 36 and 37 explain more on the measures taken by the evaluators and the field staff to ensure compliance with all standards, norms, and procedures (e.g., maintaining the **evaluators' independence, impartiality, credibility, and transparency**, focus on evaluation utility; and demonstrating respect to human rights, gender equality; and professionalism)**.** The matrix below only outlines few selected aspects.

Table 3.2: Compliance Measures Taken to Comply with UNEG/UNICEF Norms & Standards

Criteria	Compliance Measures
Conflict of Interest	• Any potential conflicts of interest and issues around integrity are investigated and addressed both when forming the core team and when training and selecting field team members.
Avoidance of Harm	• During data collection, safety of field team and respondents was endured. • All field team members were trained on the principle of avoidance of harm. • All COVID-19 related preventive safety measures (safe distancing, wearing face mask, frequently doing hand sanitization) were implemented during fieldwork.
Informed Consent	• All participants were detailed on key elements of informed consent (purpose, and significance of this evaluation and the scope of their involvement, time, volunteerism, right to withdraw at any time). • Both verbal and written informed consent was sought.
Privacy of Participants	• No outsider was allowed to interfere the FGD discussion. • All primary data (collected through HHS, KIIs/FGDs) was coded and de-identified to hide individual identity and was not revealed during analysis and reporting. • All collected data were held securely, only accessible to the authorized staff.

3.7. Risks, Limitations and Mitigation Measures

Table 3.14 below depicts limitation and the mitigation measures adopted by evaluation team.

[92] http://www.unevaluation.org/document/download/2787
[93] https://www.unicef.org/evaluation/media/816/file/UNICEF-Adapted-UNEG-Evaluation-Report-Standards.pdf

Table 3.3: Limitations, Constraints and Proposed Mitigation Measures

Risks & Limitations	Mitigation Measures Implemented
Due to COVID-19, travel restrictions and quarantine requirements, the international team could not visit GB for on-site data collection.	Increased use of technology by national and international evaluation team for remote data collection (Zoom. etc). Virtual intensive trainings were conducted for national experts, and national Partner's field staff on quality assurance checks of all data collection procedures.
The COVID-19 situation posed safety risks for all evaluation participants and the team itself.	The entire team applied risk mitigation and COVID 19 safety protocols during field data collection (please refer to section 3.7.5). Where access to respondents was not possible online interviews (through phone or Zoom calls) were conducted.
Cultural sensitivity to approach female respondents	Only female enumerators were deployed in culturally sensitive communities to ensure easy access to female respondents.
Delays in execution of evaluation due to (delays in securing secondary data; completing inception reports; and securing ethical clearance)	Delays were encountered during inception phase (in securing Programme documents and attaining ethical clearance). No cost extension was sought to extend the evaluation execution timeline.
The Programme had been implemented without a documented ToC. This posed a challenge as it was difficult to establish the intended change and the contribution that the Programme interventions may have made to create the intended change.	Based on the review of available Programme documents particularly the Community Health Strategic Plan 2015-2018 and Country Programme Documents, the Consultants reconstructed an ex-post ToC (including the related risks and assumptions) based on the literature review findings.
Some relevant data was available in language other than English.	The Evaluation team included experts proficient in French/Arabic to minimize the chances of misinterpretation and ensured 'quality' translation of the key information/data.

3.8. Evaluation Management – Evaluation Reference Group (ERG) Role

The evaluation was commissioned by UNICEF Country Office in GB (on behalf of two other countries) and UNICEF WCARO (Regional Office for West and Central Africa) extended technical oversight. This being a regional evaluation, it had two layers of Evaluation Reference Groups (ERGs), operated at regional level and at country level. Briefly, the two ERGs provided technical guidance on evaluation design, methodology, tools, implementation, and quality assurance of the evaluation outputs (Appendix 38 provides details of the role and composition of ERG in GB).

3.8.1 Evaluation Team

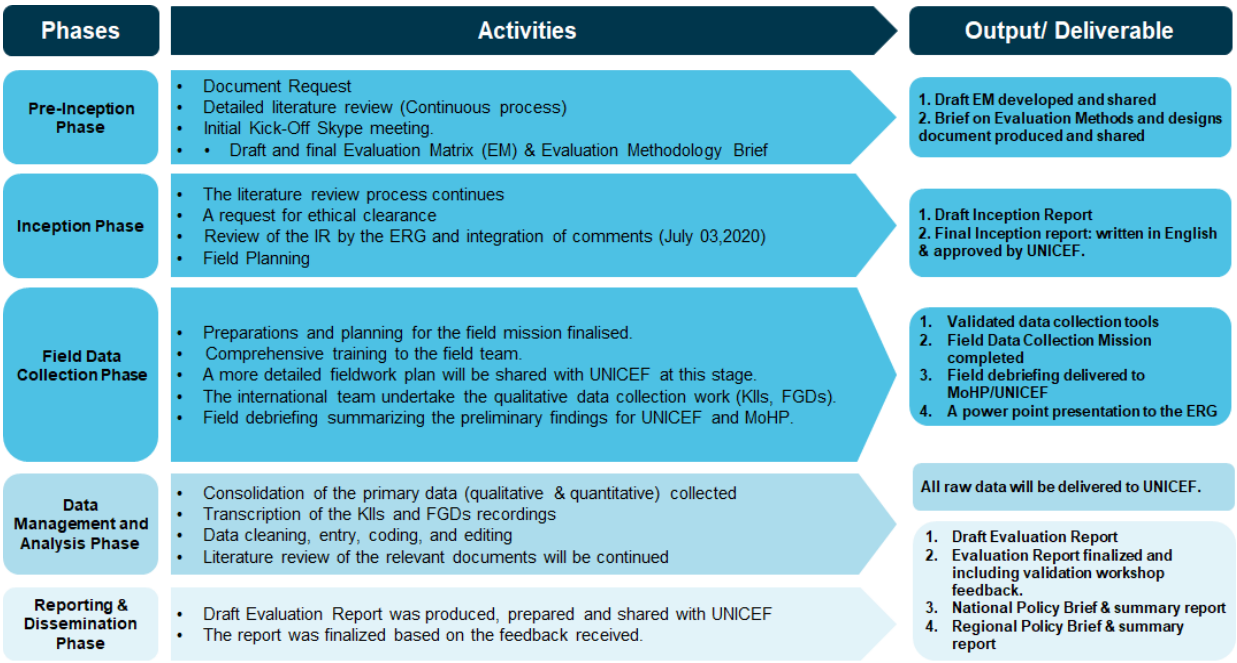
The evaluation was implemented by AAN Associates[94] as primary contract holder. AAN deployed a team of international (a common core team for all three countries) and national consultants (for each country) for the evaluation. The team selection and deployment took a considered view to balance the following considerations i.e., training background, technical skills, context understanding, field exposure, language proficiency, gender, and others. For instance, out of 10-member team (deployed in each country), half of them were women (3 international and 2 national). The overall guidance was extended by the international team (conducted remote interviews and workshops), who trained the national consultant and partner's staff and ensured quality and timely data collection. The national team comprising a community health expert and the local staff of an in-country partner (evaluation coordinator, data analyst, field supervisors for quality assurance, enumerators, moderators of KIIs and FGDs, Transcribers and translators)[95], took lead in field data collection. The need for an in-country partner was considered all the more relevant in order to ensure compliance with local context, culture, and gender norms. The Appendix 39 provides a complete team organogram, supplemented by brief profile, and description of the role of each team member in the three countries.

[94] https://aanassociates.com/
[95] National partners: Rwanda 'Coatl' is an international development consulting firm. http://coatl.pt/web/en/coatl/; Chad & CAR: 'Field Work Africa (FWA)' Website: https://www.fieldworkafrica.com/;

3.9. Evaluations Implementation Phases

The evaluation followed the standard phased approach (five phases in total) where pre and inception phases for all three countries were combined for resource optimization. The Figure 3.6 exhibits the phased approach taken with activities and interim deliverables.

Figure 3.6: Evaluation Implementation Phases



3.10. Evaluation Timeline, Deliverables and Work Plan

This multi-country evaluation was executed between Feb 2020 and December 2021. For multiple reasons (i.e., delays in securing ethical approval, COVID 19 related mobility restrictions etc), two no-cost contract extensions were granted by UNICEF GB Office. The Appendix 40 provides evaluation implementation timeline and the contractual deliverables it produced.

Chapter 4: Evaluation Findings & Preliminary Conclusions

This chapter synthesizes the findings, analysis, and preliminary conclusions around four OECD-DAC criteria i.e., relevance, effectiveness, efficiency, and sustainability. In addition, it provides analysis on UNICEF's cross-cutting programming priorities of human rights-based programming, gender equality and equity (together these are treated as non-DAC criteria). The contents have been presented in bullets and boxes for ease of comprehension for the reader. *Each criterion ends with a box where evaluators have presented the regional comparative perspective around the criterion.*

4.1. Relevance

The relevance criterion encompasses one key question and three sub-questions. The findings are structured as: i) overlaps of Programme objectives and strategies with those of host governments' sector plans and policies; ii) Programme's compliance with the national and global CH standards; and iii) relevance with the community needs.

EQ1. To what extent did the objectives, strategies, and interventions of the CH Programme, approaches and initiatives align to objectives, strategies, and interventions of national health/CH policies, strategies and plans of each of the three countries i.e., Guinea-Bissau (GB), Central African Republic (CAR), and Chad? How did these relate to community needs and global CH Programming guidelines?

EQ1.1: To what extent the objectives, strategies, and interventions of CH approaches and initiatives align with those of national health/CH plans, policies, strategies, and interventions of each country i.e., Guinea-Bissau (GB), Central African Republic (CAR), and Chad?

A CHW on a door-to-door vaccination campaign in his village - © UNICEF CAR

4.1.1. Alignment of CHP Objectives & Strategies with National and Health Sector Plans

The matrix below outlines the objectives and strategies associated with the CH Programme and approaches in each one of the three countries being evaluated (left column). In addition, it analyses the level of alignment between such objectives/strategies with those of the national and sectoral policies and plans.[96] Refer to Appendix 41 for a more detailed matrix for each country.

Objectives and Strategies of Community Health Programme (CHP) and CH Approaches (by country)	Analysis of Alignment with National & Health Plan Objectives & Strategies
Guinea-Bissau	
CHP Key Objectives: To assist the Government of Guinea-Bissau in accelerating the reduction of maternal, neonatal & child mortality. Also, to improve access and use of basic quality health services in the 11 health regions. **CHP Strategies:** 1. Essential medicines and materials and equipment. 2. The 16 EFP are promoted and strengthened in all health regions. 3. Quality nutrition services are strengthened (counselling, screening, and management). 4. The coordination and management of health activities. 5. The capacities of communities' centres for behaviour change in the WASH sector are strengthened.	• In GB, multiple plans exist to guide health sector priorities and the design and implementation of CH interventions. Key documents include National Indicative Programme (2014-20); National Strategic Plan (2015-20); National Health Development Plan II (2008-17) & III (2018-2022); National CH policy (2010); POPEN (2011-2015); and National Strategic Plan for CH (2016-2020). • CHP is assessed as "relevant" due to the alignment of its objectives and strategies with those of GoGB national and health sector plans in terms of universal health coverage, primary health care and strengthening health governance. • All stakeholders endorsed CHP's relevance as it aims to contribute to achieving the MoPH health priorities and efforts in addressing high mortality rates for pregnant and lactating women and children (U5). • The CHP is relevant in supporting MoPH's vertical programmes (malaria, TB, HIV/AIDs etc.). • The CHP is relevant as it aims to contribute to GoGB's international commitments and development agenda such as for MNCH - to 'Increase Budget Support for MNCH'; under SDGs Goal (3.1 & 3.2).
Chad	
Key Objectives and Strategies of CH Approaches: 1. **CBVP:** Community outreach; communication and social mobilization for routine immunization. 2. **CFC/RTM:** Implementation of community-based multisectoral actions; capacity building for monitoring in real time; strengthen local governance & social accountability mechanisms. 3. **1000 days Approach for Malnutrition:** Support PLW to focus on maternal and child health; strengthen capacities of health facilities and communities in	• Desk review indicates the availability of multiple documents highlighting health sector's objectives, strategies, and priorities. Key documents include National Development Plan (2017-2021); National Strategic Plan for Universal Health Coverage (2017-2019); National Health Development Plan III (NHDP 2018-2021); National Community Health Strategy (CHS 2014); Community Health Strategic Plan (CHSP 2015-18); and National Health Policy (NHP) (2016 – 2030). • The key objective of National Community Health Strategy (CHS 2014) and Community Health Strategic Plan (CHSP 2015-18) is to 'improve people's involvement in solving their health problems to help reduce morbidity and mortality. The key strategies are to focus on strengthening the institutional framework for community health; capacity building of communities to take charge of their health problems and capacity

[96] EQ1.1: To what extent the objectives, strategies, and interventions of CH approaches and initiatives align with those of National Health Development Plan-II (2008-2017) /National CH policy 2010, iCCM Strategic Plan (2016-2020), strategies, and interventions?

Objectives and Strategies of Community Health Programme (CHP) and CH Approaches (by country)	Analysis of Alignment with National & Health Plan Objectives & Strategies
monitoring of key health and nutrition indicators. 4. **iCCM:** Increase access to curative care (malaria, ARI, diarrhoea and malnutrition of children U5; involve communities and health services providers to promote preventive practices & timely care). 5. **WB/UNFPA CHWs Training:** Strengthen access and quality of services through community-led interventions.	building of health actors for increasing the accessibility of community-based health services. • Discussions with stakeholders and documented evidence indicate a clear alignment and, therefore, relevance of all CH approaches (CBVP, CFC/RTM, 1000 days approach, and iCCM) with the above listed objectives and priorities of the CHS and CHSP. • All key stakeholders (MoPH, UNICEF and NGOs) referenced that the CH approaches enabled the Government of Chad to roll out the CHSP 2015-2018; as well as to help GoChad in fulfilling its commitment to 'universal health' and 'Bamako initiative'.
Central African Republic (CAR)	
CHP Objective: 'Improve equitable access to essential care for children under 5 years to reduce morbidity and infant mortality'. **CHP Strategies:** 1. CH Institutionalisation 2. Microplanning / Situation analysis / Baseline 3. CHWs recruitment, training, and deployment to provide community-based health services. 4. Provision of CH service package (promotion of family practices) 5. CHW monitoring, supervision, and evaluation. 6. Community Participation 7. Referral and counter referral	• Multiple documents are available to highlight health sector objectives, strategies and priorities including (National Health Development Plan (NHDP 2006-2015); Health Sector Transition Plan (2015-2017); Health Sector Interim Plan (HSIP 2018 2019); and National Policy to Fight Against Malaria (2016). • The CHP is found to be "relevant" for evident alignment of its objectives and strategies with those of GoCAR national and health sector plans e.g., in terms of achieving universal health coverage, strengthening primary health care, and strengthening health governance. • The CHP contributes to GoCAR's capacity in terms of training health staff and CHWs (at community level), providing medicines (for 3 child diseases) and for filling the gap of lack of national supply system. All these priorities are GoCAR's priorities which are documented in above listed national and health sector development plans. • The CHP is relevant as it supports MoPH's vertical Programme on its fight against malaria as well as national level campaigns on immunization. • All field discussions clearly endorsed the CHP alignment for contributing to achievement of MoPH's health priorities and GoCAR's efforts to address high mortality rates for infants and children (U5).

EQ1.2: To what extend the CH/iCCM strategies, and interventions adhere to the global guidelines on CH programming e.g., by WHO, UNICEF, and others?

4.1.2. Programme's Compliance with National and Global Guidance on CH

This sub-section presents the compliance[97] (or lack thereof) of the CH Programme and interventions in each country with the national and global (WHO) guidelines. The following analysis is based on secondary and primary data sources.

[97] EQ1.2: To what extend the CH/iCCM strategies, and interventions adhere to the global guidelines on CH programming e.g., by WHO, UNICEF, and others?

Standard / Criteria (by country)	Analysis of Compliance or divergence with National/WHO standards on CH Programme
GB - National Guide IMCI 2015 suggest a 30,000 CFA monthly motivation to CHW	• **In GB,** a deviation from the national guideline was noted as the CHWs are paid less (120-180 CFA per HHs per month). • Discussions with stakeholders do not indicate any other significant deviation from the CH strategic framework in GB, except payments to the CHWs and other 4 recommendations by WHO that are mentioned below.
CAR – National Guide IMCI 2017 suggests payment of 5000 CFA per month (to be paid by communities) for CHWs to keep them motivated.	• In practice, CHW payments vary (10000 – 3000CFA) from partner to partner and from project to project. The CHP does not pay CHWs except for travel-related expenses (including per diem costs) for their participation in monthly meetings. • The evaluators noted that national standards on CH implementation are not yet available, except the CH implementation guide (developed as part of this Programme in 2017). The guide is largely consistent with WHO's guidelines and protocols (for treatment of malaria, diarrhoea, and pneumonia).
WHO Standards on CHP 1. No limitation on 'age' or 'marital criteria' for CHW recruitment and pre-service training. 2. Using competency-based formal certification for CHWs 3. 'Career Progression' should be offered to practicing CHWs 4. Leverage community-based structures to support CHW role 5. 'Use of mHealth' to support different functions of supply chain'.	1. **In GB,** the national implementation guide stipulates 18 years as the minimum age for CHWs selection. Although this is a deviation from the WHO standards, it is justified to ensure that national labour laws are not violated. 2. **In CAR,** the national implementation guide mentions the age range (25-50 years) for CHW selection. 3. **In GB and CAR:** The other 4 recommendations by WHO (regarding CHW certification, career opportunities, meaningful community involvement and use of IT) are not applied in practice for both countries.

Due to multiplicity of CH approaches in Chad, the analysis of compliance or divergence of CH approaches in this country is presented separately in the table below.

CH approaches in Chad	National/Global Standards/Guidelines	Analysis Compliance and/or Divergence
CBVP	The activities under CBVP are aligned with community outreach component of the Reach Every District (RED) Approach of WHO, UNICEF, and other partners in GAVI Alliance 2002.	The Desk review and the discussions with stakeholders[98] indicate that CH initiatives 'mostly' follow the strategies and guidance from the CHP (2014) and CHSP (2015-18), except following few inconsistencies regarding CHW role[99]: • The incentives paid to CHWs are lower (varying from 5,000-15,000 francs CFA) in comparison to the 25,000CFA (CHSP Standard). • Paired deployment of CHWs was not applied during iCCM implementation by the Mentor Initiative. (CHSP Standard). • COSAN and COGES committees are not functional in all areas or insufficiently involved (CHSP Standard).
1000 – days approach	The interventions are aligned with Infant and Young Child Feeding (IYCF) global strategy.	
CFC-RTM	CFC/RTM initiative is part of UNICEF & BMGF supported initiative "Child Friendly Community with Real-Time Monitoring".	
iCCM	This iCCM initiative takes guidance from global iCCM	

[98] MoPH, RHDs, UNICEF, NGOs, health staff at all levels (national, regional and health area)
[99] The role of CHW is central to all these CH initiatives, except for CBVP which deploys community relays (village volunteers).

CH approaches in Chad	National/Global Standards/Guidelines	Analysis Compliance and/or Divergence
	approach for providing treatment services outside the healthcare facility at community level.	Non-compliance with WHO Recommendations: • Age criteria of CHWs between 20-55 years is not recommended by WHO. • Certification for CHWs is not in practice. • CHWs do not get any career progression opportunity. • Use of technology is not evident at all levels of supply chain and/or monitoring.

EQ1.3: (How) did Programme identify community needs and how far have those evolved over time?

4.1.3. Identification of Community Needs

The following table maps the process the Programme took to identify community needs in each country. It further elaborated how far these community needs have evolved over time along with any programmatic adaptations made in line of the changing operational context.

Country	Relevance to Community Health Needs	Evolving Community Needs and Programmatic Adaptations
GB	• Literature Review and KIIs suggest that no formal assessment was ever carried out to identify community health needs. • The Programme leveraged available knowledge from PIMI-I to inform its interventions.	• No significant change was noticed in the context. The stakeholders referred to positive change in community health seeking behaviours, which they attributed to continuity interventions (from PIM-I to CHP). • No significant changes in programme design or delivery due to COVID-19.
Chad	• National surveys such as MICS 2014, ENSA 2017 and SMART were used to identify community needs. • For CBVP component, multiple LQAS assessments were undertaken i.e., 2016, 2018 and 2020. • Weak health indicators around mother and child health indicators justifies the need for CH approaches or interventions.	• Primary data suggests that political unrest in Chad and neighbouring countries (like CAR) aggravated the child and mother nutrition conditions. Eventually, as part of humanitarian response, multisectoral interventions (health, WASH, food security) were implemented by Action Against Hunger (ACF) (July 2019-2020)[100]. • COVID 19 was cited as one of the key contributors to changing community health needs.
CAR	• No formal assessment was carried out to identify community health needs. • Communities were consulted through situation analysis in each health district. The consultations included seeking communities' views on their willingness and capacities to support the establishment of community care sites and for supporting the CHW's role. Stakeholders viewed the Programme design and rollout as 'participatory'.	• The context in CAR is marred by protracted conflict and insecurity. This resulted in significant internal displacements. • The findings do not suggest tracking of evolution in context through regular assessments, nor does it appear that Programme results, interventions and resources were adapted in view of larger contextual changes, except the Programme had to replace the Haute-Kotto Prefecture with Kemo Prefecture for inaccessibility because of heightened conflict.

[100] Other involved partners were UNHCR, World Food Programme, the Mentor Initiative and Government partners.

Box # 4.1: Preliminary Conclusion – Relevance

1. **REL#1 - Alignment of objectives and strategies of the CHP and approaches:** All CH interventions in three countries are aligned with national and health sector priorities.
   - **The CHP in GB** is found to be '**relevant'** as the CH Programme's objectives, strategies, and interventions are aligned with those of GoGB national development, and health related strategies and plans[101] as it addresses priority needs. The Programme exhibits relevance due to its potential to support the MoPH supported other vertical Programmes or services such as RH, TB, HIV/AIDS, and national campaigns for malaria and immunization. The key stakeholders referred to CHP strategies and interventions[102] as relevant for prioritizing and addressing the systemic bottlenecks like weak technical, administrative and implementation capacities, shortage of human resources and poor health infrastructure/[103]
   - **The CH Approaches in Chad** are '**relevant'** because UNICEF and partners' assistance enabled the GoChad to implement the CH strategic plan (CHSP 2015-18) which was developed and rolled out to promote and implement health interventions at community level and to address systemic deficiencies of the health system (staff shortage, coverage, access) and key bottlenecks (distance, cost etc.) to access to health care.
   - **The CHP in CAR** is concluded as '**relevant**' for its evident overlaps with the objectives and strategies spelled out in the national and health sector plans (NHDP 2006-2015, HSTP 2015-2017, and HSIP 2018-19). The interventions are considered 'relevant', as well, in that they contribute to prioritising those child-centred diseases (malaria, diarrhoea, pneumonia) that most contribute to child morbidity and mortality (130 deaths per 1,000 live births for children U5). Also, CHP contributes to GoCAR's efforts with respect to national and international commitments e.g., achieve universal health coverage, commitments made under 'Bamako initiative', and those of SDGs (particularly 3.2 - to end preventable deaths of newborns and children under 5 years). The CHP rollout in each prefecture was guided by consultations with health authorities and communities.

2. **REL#2 - Compliance with national and international guidelines:** All CH interventions in GB and CAR, and CH approaches in Chad 'mostly' comply with relevant national and global guidelines on CH programming. Despite the broader compliance, few exceptions are noted with regard to identification and selection (age and marital status) of CHWs, inconsistent and low level of compensation for CHWs than as are prescribed by national guidelines, partial compliance to paired deployment of CHWs (one male and one female), absence of career progression opportunities, lack of certification for CHWs and limited IT use in CH. In CAR, national CH standards does not exit; however, the CHP implementation was mainly guided by the national implementation guide which was developed as part of implementation.

3. **REL#3 - Identification of community needs and their evolution:** In all 3 countries, CH interventions were designed based on secondary evidence (national surveys and health sector policies or plans). Evidence points to persistent weak indicators around mother and child health to justify the need of CH interventions and approaches. In the operational context, no significant change is noticed in three countries except the political unrest and conflict situation in Chad and CAR during implementation (which led to the replacement of Haute-Kotto Prefecture with Kemo Prefecture in CAR). Emergence of COVID-19 has some effects on pace of implementation in all three countries. No evidence available to indicate any other notable programmatic adaptations due to contextual changes in these countries**.**

[101] PNDS II & III (2008-2017 & 2018-2022), National CH policy/directive (2010-11) and POPEN 2011-2015.
[102] Capacitating the RHDs and health area staff, establishing CHW network, mobile and advance strategies, door to door visits by CHWs, implementation of EFPs, provision of medicines etc.
[103] Key challenges, where the CHP efforts and contributions are relevant includes weak technical, administrative and implementation capacity, shortage of human resources (244 Doctors, 1,379 nurses) for health, fewer health structures (123 health centres in 117 health areas at local level; 5 regional hospitals and 03 referral centres at national level) out of which almost half of these (54%) are considered in good working conditions and the remaining are either having poor working conditions or dysfunctional[103] or have been closed (PNDS-III / UNICEF 2017)

4.2. Effectiveness

The following section presents the findings on the achieved objectives and results for each country. The findings are structured in three parts: 1) Programme's achievements and contributions; 2) Unintended results; and 3) Programme's Partnerships. The findings for each country are presented separately due to variance in the nature of interventions implemented. The Appendix 41, 42 and 43 provides details of results and assessment tables for each of the 3 countries.

EQ2. To what extent did the CH Programme, and approaches/strategies achieve their own objectives and by extension contribute to national plans/policy objectives in three countries? How internal and external factors either enabled or hindered the achievements?

EQ2.1: How far did the CH approaches and initiatives in each country achieve its own objectives?

EQ2.2: How far did CH approaches and initiatives contribute to achievement of national plan and policy objectives in each country (i.e., national strategic plan and the national policy in Guinea-Bissau, EU-funded Programme in CAR and Community Health Approaches/Strategies in Chad)?

The community health worker, Djara Djante during a sensitization session on 16 key family practices. © UNICEF Guinea-Bissau / 2018 / Rodriguez

4.2.1. CHP Achievements and Contributions (by country)

Guinea-Bissau

1. In order to measure the effectiveness of the CH Programme based on the logframe indicators used by the UNICEF CO and its in-country partners, the evaluators relied on secondary data including the UNICEF's CHP Progress Report 2018-2019 and MICS results (2018-19).
2. Overall, the CHP fared as 'Partially Effective'[104] in achieving its goal and specific objectives (see Appendix 42 for complete results on all indicators). Around the intended goal level achievements, the MMR indicator has not been assessed for lack of official reported data (also not reported in MICS 2019). For child U5 mortality, the target is achieved in terms of numbers (reduced from 89 to 51 per 1000 live births). However, due to 'partial achievements' around 11 indicators of the specific objectives and five outputs, the overall effectiveness of the Programme is assessed as 'Partially Effective'.
3. Around the specific objective indicators, out of eleven key indicators, two (2) indicators *(i.e., ANC4 rate; children U5 sleeping under LLINs)* 'achieved' the defined targets, six (6) indicators *(exclusive breastfeeding; immunization coverage; delivery by trained personnel; children U5 with malaria treated properly; children U5 with pneumonia treated with antibiotics; children U5 having diarrhoea treated with ORS & Zinc)* were assessed as 'mostly/almost achieved', while two (2) indicators *(C.U5 with growth retardation; and C.U5 with global acute malnutrition)* could not achieve the stated targets. One indicator (rate of outpatient children U5) was not assessed for data limitations (see Appendix 42 for complete results on all indicators).
4. The partial effectiveness of the Programme is mainly due to the operational context (continued political instability) and various challenges (institutional, financial, and social factors and evolving nature of the Programme) faced during implementation, which hindered the attainment of the envisaged targets.
5. Of the five CHP key strategies/components, two strategies (promotion of EFPs, and management and coordination of CH health services) worked well and are assessed as 'mostly effective'; the other two strategies (essential medicines, and nutrition services) are rated as 'partially effective' and the last one (WASH interventions) is assessed as 'least effective' (for more details, see the table below). Please note that the results fully achieved or overachieved are indicated in dark green; those almost (mostly) achieved are indicated in lighter green; those partially achieved are indicated in yellow; and those not achieved are indicated in red.

Central African Republic (CAR)

Programme documents lack clarity on targets (on extent of reduction) and there is no baseline available for the six targeted prefectures implementing CH approaches and included in the evaluation sample. The Programme reports do not specify either the level of progress over time against the Programme's overall objective. The evaluators used the existing secondary data to measure the change in infant and child mortality rates. Overall, the data extracted from two sources (MICS 2010 vs 2019 and UNIGME 2015 vs 2019) attests to a general downward trend in mortality rates (for children under five) and therefore seems to suggest a possible contribution of the Programme to such improvement[105]. Below are some of the Programme results:

- The Programme managed to set up 193 community care sites in 6 prefectures against the target of 193. For two prefectures i.e., Bamingui-Bangoran and Nana Membrane, the Programme exceeded its targets (refer to Figure 2.3 for Prefecture-wise progress).
- The Programme identified, trained, and deployed 193 CHWs with the focus to treat 3 child diseases and for screening and making referrals cases of malnutrition in children under five.
- Against the set target to treat/refer **304,684** cases[106] associated with the 3 most lethal diseases of or children plus 870 cases of malnourished children under five), the CHWs could manage to

[104] To ensure an 'objective assessment', the Evaluators developed and used an assessment grid which is given in **Appendix 29.** 'Fully Effective' refers to Programme interventions and results that achieved all intended results. "Mostly Effective" refers to Programme interventions and results where most of the interventions achieved the set targets or intended results. 'Partially Effective' refers to those Programme interventions and results where only some of the constituting interventions achieved the set targets or intended results. "Least Effective" refers to Programme interventions most of the constituting interventions could not achieve the set targets or results. [Achievement status refers to comparison with set targets and reported results]

[105] The observed reduction in mortality rates cannot exclusively be attributed to Programme efforts, because of various other development interventions in broader health and other related sectors (education, WASH, food security and others).

[106] Programme logframe

treat/refer **only 82,067 cases.** The achievement rate comes to **27% of the planned target.**[107,108].

- The Programme's other key contributions include the development of a national CH policy (which was not available at the beginning) and other normative documents aimed to strengthen the institutionalization of CH in nationwide. These include guidelines determining the selection criteria for CHWs, health centers, and communities for care sites, the type of training materials to be used, and the kind of data collection tools and CHWs reporting formats to use on the ground.
- All stakeholders greatly appreciated the participatory and collaborative nature of the process adopted for developing these documents. This collaborative process helped the Programme in harnessing a strong commitment and ownership of the MOPH with the active involvement of the Minister of Health.
- The logframe does not provide any specific targets around capacity building of various actors. However, a series of training sessions or workshops were organized for creating a pool of master trainers on CH at the national and regional levels who in turn provided training to CHWs.,
- In each one of the 9 health districts included in the CH Programme, 1-2 health staff were trained including one nursing supervisor (as CHW supervisor) of the reference health centres (107 health centers).
- In general, most of the stakeholders regarded the training content, delivery by master trainers, and technical skills of CHWs as optimum and adequate to provide basic treatment of the simple malaria, cough with fever (pneumonia) and diarrhoea cases.
- The logframe does not include any specific indicator around EEPs promotion.[109] This remains a design gap. The promotion of essential family practices (EFPs), particularly around mother health, could not be prioritized until 2018 and particularly during initial phase of implementation (in the two prefectures Nana Gribzi and Ouham). One key reason was the Programme's inability to get community-based women groups involved for promotion of EFPs and Income Generating Activities (IGA) mainly due to non-availability of government approved selection criteria for engagement of women groups.

[107] In terms of % progress achievement (target vs. treated cases) for each of the 3 diseases, the targets could not be achieved (33%, 25% and 20% cases of the targets were achieved around Malaria, Pneumonia, and Diarrhoea cases respectively).
[108] UNICEF's Final Progress Report (September 2019): Support for cases of childhood diseases at Community level in the CAR
[109] No indicator around key aspects of mother health i.e., pre, and post-natal care, assisted birth, birth at facility, exclusive breastfeeding etc.

Chad:

This sub-section presents findings on effectiveness of CH Approaches in Chad. All CH approaches were implemented as part of CHSP, therefore at first, the success/effectiveness of the CHSP are presented in the below Table, followed by summarized assessment of each CH approach.

Effectiveness and contributions of the CHSP

Strategic Priorities (CHSP 2015-2018)	Achievement Status[110]
Axis 5: Strengthening monitoring and evaluation	1/22*100= **5%**
Axis 4: establishment of an institutional framework & mechanisms of coordination	8/20*100= **40%**
Axis 3: strengthening community participation	1/16*100= **6%**
Axis 2: strengthening the offering of integrated services & quality	4/25*100= **16%**
Axis 1: Strengthening the skills of health providers	7/17*100= **41%**
Overall Achievement	21/100*100= 21%

Effectiveness of CH Approaches.

Strategy	Achievements	Challenges	Conclusions
Community Based Vaccination Promotion	The performance against all four targeted vaccination indicators has improved: • vaccination coverage for children 12-23 months is increased by **10%**, vaccination coverage for Penta3 vaccination coverage increased by **19%**, the IPV coverage increased by **48%** points, decrease in Penta3 dropout rate by **16%** points. • key achievement: '56.5% of never vaccinated children' and '75.8% of incompletely vaccinated children' and issuance of vaccination card to 73% of children in the targeted districts.	• The health sector is facing governance and accountability issues that affected the regular payments for civil servants. • Decreased routine immunization activities between Jul - Dec 2016 due to general strike by health workers. • Supply side barriers due to inadequate cold chain, weak vaccine supply, management system and human resources resulting in frequent stockouts.	Overall vaccine coverage remains low in Chad. There were increases in vaccine coverage in more than 60% of the targeted districts in all five regions that implemented the community approach. However, vaccination coverage in 40% of the targeted districts could not improve. Therefore, cumulatively, it is rated as **'Partially effective'**
Child friendly Communities initiative with Real time	**Outcome1:** 7 Out of 18 targets were fully achieved (source: CHW Register data). **Outcome2:** 12 of 30 Multisectoral platforms organized advocacy meetings with local government. **Outcome3:** the performance against 03 indicators (ANC4, complete vaccination, and delivery at facility) indicates significant improvement.	Beside the positive aspects of CFC/RTM, the implementation faced some key challenges regarding involvement of local leadership, mobilization of local resources, continuous supply of inputs at health centre level, and weak coordination and sense of low accountability at upper levels (provincial health delegate) than the health area level.	Out of five outcomes, 1 and 4 indicate significant progress. For 2 & 3, some progress is noted and for 5, no progress is noted. Hence, cumulatively, this initiative is rated as **'Partially Effective'**.

[110] 0-25 Red; 26-50 Yellow; 51-75 Green; and 76-100 Blue

Strategy	Achievements	Challenges	Conclusions
	Outcome4: the targets of 3 out of 4 indicators were achieved (availability of community registers & training of CHWs using them). **Outcome5:** Increased service utilization at 02 health centres and is assessed using the health facility data (RMAS data).		
1000-Day Approach for prevention of malnutrition	**Goal:** Out of four listed indicators, targets for two indicators were achieved (% of infants U5 breastfed; % of infants affected by SAM). **Output 1:** Out of 08 listed indicators, the targets of 7 were achieved. **Output 2:** Out of 06 listed indicators, the output level targets of 03 indicators (assisted births, breastfeeding, ANC visits) were achieved.	• Inadequacy of qualified personnel and lack of technical care facilities in some health centres. Also, an imbalance between heightened demand and lack of capability of the local health system to respond to the increased demand for services. • The limited coverage (implemented in only 02 health districts) and short time frame (11 months implementation) of implementation.	At Goal level, 02 of 04 intended output level targets were achieved. However, no progress around inclusion of nutrition activities in the minimum package of health structures. At output level, most of the stated results (10/14) were achieved. Therefore, cumulatively, this approach is rated as **'Mostly Effective'.**
Integrated Community Case Management	**Output 1:** All outputs level targets (08 indicators) have been achieved. **Output 3:** Out of 04 listed indicators, the output level targets for 03 indicators were achieved.	• Key challenges during implementation included difficulty in accessing few villages during rainy seasons. • Malaria incidence was high due to lack of bed nets and posed a risk for staff of NGOs and CHWs. • Stock out of malaria drugs for adults was causing reluctance among household heads to support the CHW activities.	Most output level targets were achieved but quality of implementation (i.e., monitoring, supervision, community participation, involvement of health staff) were not emphasized, hence intended achievements were not visible. Therefore, it is rated as **'Partially effective'**.
Integrated Package with focus on Immunization	Six outcome level targets were achieved (Provision of 155 refrigerators and 195 motorcycles, training of 247 health workers for maintenance of solar refrigerators, at least 80% districts with functional refrigerators at HCs and motorcycles at district offices)	Adequate fuel and budget for repair and maintenance of motorcycles was not available in all health district offices.	Out of 9 indicators, 6 achieved targets whereas the performance against the remaining 3 (CHWs communication, coverage of Pentavalent and measles) remained unchanged. Therefore, it is rated as **'Partially effective'**.
1000 CHWs Training	Stated targets are fully achieved for 8 indicators while one indicator shows 88% achievement rate.	Feedback on quality of training was not well documented in Programme documents.	Stated targets for all 8 indicators are fully or almost achieved. Also, for 3 indicators, progress slightly exceeds the targets. Therefore, it is rated as **'Fully Effective'.**

EQ2.3: What unintended results (positive and negative outcomes) were produced by the CH interventions?

4.2.2. Unintended Results

This section captures unintended results due to Programme implemented within each country.

Guinea-Bissau	Chad	CAR
The CHWs were perceived as a 'Role Model', a source of encouragement for young girls (either in school or out of school) to pursue their education. The Programme has contributed to added recognition and respect for female CHWs. In some tabancas, the girls who were out of school, have joined literacy classes with the intention to getting necessary education to become eligible for CHW.	A few respondents in Chad shared that there are several remote areas where there is no health staff at health centre. Due to lack of proper supervision in such areas, trained CHWs/CRs were going beyond their scope (prescription of antibiotics etc.) and were acting as fake medical practitioners. This was not intended by CH approaches.	Primary (FGDs and KIIs) and secondary data do not point to any unintended effects (positive or negative) of the CH interventions.

Box # 4.1: Preliminary Conclusion – Effectiveness (Programme Achievements and contributions)

1. **EFF#1 - Programme's achievements against intended results:** In all three countries, the CH Programme and approaches were concluded as 'partially effective'. This is attributed to the fact that in Chad only 20% activities could be implemented and that in CAR the Programme managed to treat 27% of the planned cases (for three diseases). That said, in both GB and CAR, the trends suggest reduction in infant and child mortality rates. Across the three countries, the interventions have been successful in placing CH as public policy priority for the health managers. Moreover, the hybrid approach has enabled public officials to get first-hand experience of managing/contributing to CHP delivery. Due to significant variations at the design level and for implementation approaches, the conclusions are presented separately.
2. **EFF#2 - Guinea-Bissau:** Overall, the CHP was 'Partially Effective'. At goal level, the Programme managed to achieve the targets associated with only two indicators (i.e., mortality among children under five is reduced from 89/1000 live births in 2014 to 51/1000 live births in 2019 - as per MICS6 2016). The reduction in maternal mortality rates could not be established due to limited reliable data (MICS 2019 did not report data on MMR)[111]. Regarding its specific objective (outcomes) "*improve access and use of quality basic health services to children under five and pregnant women in 11 regions*". At outcome level, of the total 11 indicators, the Programme managed to achieve (either fully or partially) the targets on 8 indicators [ANC4, children sleeping under LLIN, exclusive breastfeeding; immunization coverage; delivery by trained personnel; Malaria treated properly (in children U5); Pneumonia treated with antibiotics (in children U5); diarrhoea treated with ORS & Zinc (in children U5); and Children (U5) with growth retardation.; 2 indicators (% of children U5 with growth retardation; and children U5 with global acute malnutrition) could not be achieved; and 1 indicator (rate of outpatient children U5) could not be assessed.
3. **EFF#3 - Chad:** The overall CHSP implementation is assessed as 'Least Effective' for the reason that at output level, accomplishments are only about 21% of the established targets. Most output level activities either could not be initiated or completed. As part of CHSP implementation, four key CH approaches (CBVP, CFC/RTM, 1000days, and iCCM) were implemented with technical and financial support mainly by UNICEF and other partners (WB, BMGF/GF, UNDP, SDC and others). The detailed analysis of results and achievements of these approaches yielded an overall assessment of 'Partially Effective' for 3 approaches (CBVP, CFC/RTM, and iCCM), except the '1000 days approach' which is assessed as 'mostly effective' and the 1000 CHWs Training initiative which are both assessed as 'Fully Effective'. The CH approaches have certainly contributed in terms of localized

[111] MMEIG (2017), MMR is 667/100,000 live births, however, not been validated by Govt. so not used for assessment.

Box # 4.1: Preliminary Conclusion – Effectiveness (Programme Achievements and contributions)

improvements in health status of mother and children for some indicators (vaccination, ANC4, breast feeding, birth at facility, and screening/referral of SAM).

4. **EFF#4 - CAR:** The Programme is assessed as 'Partially Effective' for varied extent of achievements at output and outcome levels. The Programme had contributed to reducing child mortality rate in CAR (target not available and the extent of contribution cannot be determined) and setting up community care sites. The Programme only achieved 27% of the planned output targets for treating /referring cases of 3 diseases that are most lethal to children (pneumonia, malaria, and diarrhoea) and malnutrition. The Programme's other contributions are evident in terms of gaining Government's commitment, drafting the first CH Policy, developing a CH implementation guide, providing training to a cadre of master trainers and 193 CHWs, and establishing 193 community care sites. The Programme is assessed as 'mostly effective' around two key strategies, i.e., institutionalization of CH, and capacity building of health staff at various levels. No notable achievement is noted around promotion of family practices.
5. **EFF#5 -** The CH Programme and approaches did not demonstrate any significant unintended negative effect in all 3 countries.

EQ3. To what extent did Programme manage to effectively identify and address the systemic gaps in different elements of national CH Programme, or CH approaches/strategies? How different internal and external factors either enabled or hindered the achievements?

EQ3.1: How well did CH approaches and initiatives identified and addressed the following in each country: CHW role & recruitment; (ii) CHW training; (iii) CHW accreditation; (iv) equipment & supplies; (v) supervision; (vi) CHW incentives; (vii) community involvement; (viii) opportunity for advancement; (ix) data quality and use; and (x) linkage to health system?

4.2.3. CHW Performance Assessment (CHW Functionality Matrix by WHO)[112]

The findings are drawn using the WHO suggested CHW Functionality Matrix tool[113] for the assessment of CHW performance. As part of this assessment, the evaluators adopted and used 70 indicators (grouped into 10 thematic components) as are given in the functionality matrix. The evaluators implemented a two-step process. The first step entailed the assessment of the Programme and approaches in the three countries against each indicator falling under each one of the 10 thematic components. The second step consisted in determining the aggregate score for all the indicators falling under each one of the 10 thematic components. The performance and effectiveness of CH Programmes and approaches were rated according to the four-level rating scale recommended by WHO structured as follows a) Non-Functional, b) Partially Functional, c) Functional, and d) Highly Functional. *The Appendix 31 provides all details of the two-step process[114] adopted by evaluators along with the description and assessment of each indicator for all 10 thematic components (functional areas of CHW role).* The matrix below provides summary assessment for the three countries. Overall, **the assessment yielded 'partially functional' rating of the CH Programme for all three countries.** The Appendix 44 provides separate summary and detailed assessment for each country.

[112] EQ3. To what extent did Programme manage to effectively identify and address the systemic gaps in different parts of CH Approaches/Interventions? How different internal and external factors either enabled or hindered the achievements?
The sub-section outlines findings on one sub-question. EQ3.1: How well did CH approaches and initiatives identified and addressed the following in each country: I. Role and recruitment? II. Training of CHWs? III. Provision of necessary drugs and equipment, including the establishment of a continuous supply system? IV. Support for the implementation of interventions aimed at increasing the use of the services (demand creation); V. Implementation of a performance review system for CHWs? VI. The supervision plan and its implementation? VII. The establishment of a reference and counter-reference system? VIII. The establishment of a monitoring system for community care interventions?

[113] WHO assessment scale a) Non-Functional, b) Partially Functional, c) Functional, and d) Highly Functional.

[114] The two-step process was adopted for assessment. **Step#1** - Indicator Level Assessment Scoring Grid [Not Achieved or no compliance = 0; Partially Achieved/Comply= 0.5; fully achieved/complies=1]; **Step#2** Rating Grid [Non-Functional < = 25%; Partially Functional 26-50%; Functional 51-75%; Highly Functional 76-100%].

Thematic / Functional Area	Guinea-Bissau		Chad		CAR	
	Assessment Score[115]	Functionality Rating	Assessment Score	Functionality Rating	Assessment Score	Functionality Rating
Role & Recruitment	54%	Functional	38%	Partially Functional	62%	Functional
Training	44%	Partially Functional	31%	Partially Functional	56%	Functional
Accreditation	0%	Non-Functional	0%	Non-Functional	17%	Non-Functional
Equipment & Supplies	44%	Partially Functional	33%	Partially Functional	53%	Functional
Supervision	67%	Functional	28%	Partially Functional	44%	Partially Functional
Incentives	31%	Partially Functional	31%	Partially Functional	34%	Partially Functional
Community Involvement	43%	Partially Functional	50%	Partially Functional	36%	Partially Functional
Opportunity for Advancement	0%	Non-Functional	0%	Non-Functional	0%	Non-Functional
Data (quality, use)	36%	Partially Functional	29%	Partially Functional	43%	Partially Functional
Linkage to Health System	31%	Partially Functional	25%	Non-Functional	34%	Partially Functional
Overall Assessment	**41%**	**Partially Functional**	**31%**	**Partially Functional**	**44%**	**Partially Functional**

Box # 7: Preliminary Conclusion – CHW Performance Assessment

6. **EFF#6 -** In all three countries**,** the CHW performance or CH Programmes are concluded as 'partially functional'[116] with varied level of achievements or gaps around 10 thematic components. On relative comparative basis, the CHW role is weaker in Chad in comparison to GB and CAR. The integration of CHW into formal health system, and their accreditation are 'not functional' in any country. This comparative conclusion is drawn from the following conclusions for each country.
7. **EFF#7 - Guinea-Bissau:** The CHW performance and programme is rated 'partially functional' since out of 75 total score/indicators, the achieved score is 31 (41%). The monitoring, supervision, and performance review system of CHW have worked relatively better than others, mainly due to NGO led system. Nevertheless, the implementation faced several operational issues such as weak coordination and overlapping priorities of regional health teams undermined the value of microplanning. Likewise, referral system did not work well mainly due to lack of logistic facilities and non-availability of services for treatment of malnourished children at health facility level. Some enabling factors include NGOs- led implementation, adaptive programming, and CHW commitment and interest in some communities. Whereas traditional beliefs and practices, and low participation of women proved as key disablers to smooth implementation and the achieved results.

[115] Assessment score is calculated by (No. of indicators for which target is achieved/Total No. of Indicators) * 100
[116] WHO assessment scale a) Non-Functional, b) Partially Functional, c) Functional, and d) Highly Functional.

Box # 7: Preliminary Conclusion – CHW Performance Assessment

8. **EFF#8 - Chad:** The CHW performance and programme is rated 'partially functional' since out of 75 total score/indicators, the achieved score is 23 (31%). The hiring, and training of CHWs, and equipping them with necessary supplies worked relatively better. All other key aspects (monitoring, supervision, performance review, data collection and quality of data; and referral system) were weak mainly due to weaknesses of the health system (shortage of staff, weak coordination, lack of logistic means, and overlapping priorities of regional health teams). Key enabling factors were NGOs led implementation, use of visual content for training, implementation of innovative models of community-based interventions (community register, multi-sectoral platforms, child-friendly care groups) and incorporation of key lessons from neighbouring countries to inform the design and implementation of CH approaches. Most evident disabling factors were inadequate support by local coordination structures (COSAN & COGES), lack of public funds for CH, weak accountability norm within health system, meagre financial capacity of communities to support CHW role, low incentives for CHWs among others. Female participation as CHWs was low (due to barriers of long distance and weak involvement in decision making by women) and has caused difficulties for male CHWs in accessing pregnant and lactating women in some Muslim communities.
9. **EFF#9 - CAR:** The CHW performance and programme is rated 'partially functional' since out of 75 total score/indicators, the achieved score is 33 (44%). The 3 components (CHW recruitment, training and provision of necessary equipment and supplies worked relatively better are assessed as 'functional'. The collaborative efforts between UNICEF, NGOs, and the Ministry of health mainly contributed to appropriate recruitment and training of CHWs, as well as for availability of medicines and supplies. Other five components (supervision, incentives, community participation, data collection and linkages with health system) were weak. Key enabling factors includes Ministry's involvement in planning and implementation, availability of national and international community experts, customization of graphical training content and implementation guide to drive the implementation processes. Some key disabling factors included lack of CH policy and implementation framework at the start, abandonment of field missions for certain time, delays in contract renewals of NGOs, weak community participation, low incentives for CHWs, and political instability and insecurity in some areas.

EQ4. To what extent did Programme leverage partnerships to achieve results?

EQ4.1: How well did Programme cultivate inter-sectoral partnerships for community-based interventions i.e., micro-planning, implementation and monitoring of community-based activities? How far these partnerships (strategic and with IPs) worked in enabling achievement of results?

4.2.4. Programme Partnerships

This sub-section offers findings on Partnerships in the three countries which were fostered to synergize the inputs and for roll out of the CH interventions. Key findings on each country are as follows:

Guinea-Bissau: For CHP planning and rollout, UNICEF developed partnerships with Ministry of Public Health (MoPH); Regional Health Directorates; and implementing partners (AIFO, AMI, MdC, Plan, VIDA). The MoPH supported the Programme by mobilizing financial and technical resources from UNICEF as co-financer of the Programme, EU as the main donor and other partners (Global Fund/UNDP and World Bank) for their technical and financial support. Although the MoPH was engaged from the beginning of the Programme, however, it was not much involved in providing any implementation support except developing and maintaining relationship with donors and partners. All respondents (from Government, UNICEF, IPs, Donor/partners) mostly appreciated the engagement of I/NGOs to lead the implementation. There were multiple instances where IPs/INGOs highlighted the lack of resources, weak coordination, and cooperation from Regional Directorates. Overall, the relationship between UNICEF and IPs remained smooth and enabling to each other. The collaboration with the WB resulted in leveraging WB funds for payments to CHWs. The Programme could not foster a culture of effective knowledge sharing and learning across partners and Regions, except for convening few national review meetings.

Chad: The MoPH is working with multiple technical and financial partners (UNICEF, GAVI/BMGF, UNDP, Global Fund, World Bank) to seek their inputs for implementation of CHSP activities. UNICEF is supporting Government in implementation of pilot initiatives on CFC-RTM and 1000days approach for prevention on malnutrition. UNICEF is also collaborating with GAVI/BMGF for rolling out CBVP activities for immunization services. UNDP and global fund are supporting the CHSP implementation around Malaria prevention and treatment. The World Bank and UNFPA provided their support for training of 1000CHWs. These partnerships have helped GoChad/MoPH to strengthen the CH institutional and strategic framework by developing different strategic documents and in developing and piloting different CH Approaches. At the regional level, health delegates (MoPH representation in regions) are collaborating with different NGOs who are involved in implementing CH interventions. No formal contracting or partnerships are evident between RHDs and NGOs. All NGOs were directly contracted by TFPs. Generally, NGOs are maintaining minimum level of necessary coordination with RHDs. At regional and district level, RHDs and local tier of health system are working with different NGOs, which proved an effective strategy. The mutual collaboration and cooperation are relatively better at lower levels than at the regional level. Key issues at local level are weak coordination, lack of logistics and inadequate staff within health system, are contributing to irregular monitoring, and supervision of CH activities. Therefore, more public investments and efforts are required to strengthen the monitoring and supervision functions (See recommendation# 3).

CAR: UNICEF's partnership with MoPH proved effective in leveraging GOCAR's ownership, commitment, and involvement right from the design stage to initial planning and roll out of the Programme. The MoPH actively supported the Programme through its participation in various briefing and workshops. The MoPH designated a Community Health focal person at the national level and in the targeted regions to coordinate with UNICEF and NGOs. Generally, the regional health teams' role was limited to participation in various workshops including the Programmatic reviews and for planning and execution of joint field missions (MoPH, UNICEF, Regional health staff, and sometime the EU member). For the implementation of planned activities, UNICEF developed formal partnerships with two international (CSSI, MDA) and three national NGOs (CARITAS, AFRDB, JUPEDEC)[117], were selected based on their comparative advantages (coverage in area, experience etc.). The engagement with I/NGOs proved effective in developing microplanning capacities of the district health officials and helped in filling the gap of unavailability of health staff (nursing supervisor) to train and supervise the CHW. The NGOs contracts were of short duration (8 months) and some challenges were faced in the renewal of their contracts due to technical gaps in initial contracting.

Box # 7: Preliminary Conclusion – Partnerships

10. **EFF#10 - In** all three countries, UNICEF worked with respective health ministries, regional/provincial health teams, I/NGOs, and multiple technical and financial partners. Overall, this collaboration worked well as it helped in planning and rolling out the CH Programme in GB and CAR and CH approaches in CAR. Following are specific conclusions on quality of engagement and contributions of partnerships in each of the three Countries.
11. **EFF#11 - Guinea-Bissau:** UNICEF collaborated with Government, five I/NGOs as IPs, the EU (as main donor) and other technical and financial partners. UNICEF engagement with these partners have contributed to leveraging additional resources (co-financing by I/NGOs). The MoPH role to support the Programme was limited as the Programme was implemented in isolation of two key Ministries (Finance and Planning) so their influence in mobilizing more public funds could not be leveraged effectively. At regional level, the relationship between UNICEF and IPs, as well as with regional directorates was effective for planning, reviewing progress and to resolving the implementation challenges. The collaboration with WB resulted in leveraging WB funds for payments to CHWs. However, with UNDP/Global Fund, it was partly effective (due to non-availability of antimalarial drugs in some regions). The strategy to include IPs with prior experience of CH implementation in GB worked well due to their broader understanding of the local context.
12. **EFF#12 - Chad:** The MoPH partnerships with development partners are working well in terms of leveraging their financial and technical support around CH approaches. These has enabled MoPH to develop multiple strategic documents and implement CHSP through different CH approaches and interventions. A critical conclusion about partners' role is that the latter are steering the MoPH agenda as if it were their own mandate, thus leading to a lack of geographic convergence, inconsistent

[117] Two international NGOs: International Health Support Center (CSSI), DOCTORS of Africa (MDA); and three national NGOs including CARITAS Bouar, the rural Batangafo Women Development Association (AFRBD) and Youth united for the Protection of the Environment and Community Development (JUPEDEC)

Box # 7: Preliminary Conclusion – Partnerships

implementation, and weak integration of CH interventions. Also, the partners have few concerns about the MoPH role in terms of its low involvement and weak leadership. At regional and district levels, RHDs and local tier of health system are working with different NGOs, which proved an effective strategy.

13. **EFF#13 - CAR:** For Programme planning and implementation, UNICEF partnership with MoPH worked well in gaining Ministry's involvement, commitment, and support for the Programme. The partnership resulted in defining and executing programme management arrangements within MoPH. The collaboration between UNICEF and MoPH contributed to the development and approval of some essential documents (training materials, implementation guide) that were required for the Programme implementation. The role of the Regional CH Focal person was limited to attending the programmatic review workshops and facilitating coordination between NGOs and district level health teams. At local level, health staff coordinated with NGO in the management of community care sites and role of CHWs. UNICEF's partnerships with implementing partners (2 INGOs, 3 NGOs) were 'mostly' effective as it enabled the community care sites management, stock taking of supplies, and monitoring and supervision of CHW role among others. It also helped in filling the gap of unavailability of health staff in some places. The NGOs-led implementation helped in enhancing technical and implementation capacities of the district health teams. The Programme focused on organizing programmatic reviews, however proper documentation and dissemination of learning was not prioritized. In parallel, the efforts on ensuring the Programme visibility (including the UNICEF, EU, and MoPH) at various platforms worked better.

4.1. Efficiency

There is one key evaluation question and one sub-question for efficiency criterion. The findings are presented to cover all aspects of the evaluation question, such as adequacy of available resources (funds, supplies, human resources, cost per beneficiary, and time factor) and description of possible alternate strategies for cost optimization. The findings are drawn from detailed review of the key financial documents and primary data gathered during data collection.

EQ5. To what extent Programme resources – financial, human, and supplies were sufficient (quantity), adequate (quality) and distributed/deployed in time vis-à-vis planned results? Could same results be produced with alternative strategies at lesser costs?

EQ5.1: How far the Programme resources (human, financial and supplies): a) sufficient b) adequate and c) deployed in a timely manner vis-à-vis planned result?

Delivery of medicines and small equipment, thanks from the village chief. © UNICEF CAR

The Table below summarizes key findings on Programme's efficiency for all three countries:

	Guinea-Bissau	Chad	CAR
Funds adequacy, and distribution	• The total budget allocated for the CH programme was **€6 million** out of which only 75% is utilized during implementation (August 2017 to July 2019) indicating less efficient financial resource management. • Most of the KII respondents shared that available budget was inadequate to cover all needs of the implementation. Specifically, the inadequacy of funds was highlighted for implementation of advance strategy, fuel for motor bikes, repair, and maintenance of bicycle of CHWs and motorcycles for supervisors. Also, low incentives for CHWs were highlighted by every respondent as a demotivation factor. • The distribution of funds and expenditures across different cost heads also point to some imbalance (17% was allocated for contractual services however less than 1% was spent, it raises questions on the actual need for this allocation).	• Total funds for multiple CH approaches were **$5.7 million**. All stakeholders (Govt., NGOs, and UNICEF) consistently mentioned inadequacy of funds for community health interventions. So far, Government has not mobilized any public funds for community health. • All CH initiatives are being financed with donor funds, except the immunization activities where Govt. is contributing through its routine health system resources. • Evidence also points to 'imbalance' of distribution of funds. For instance, funds were limited logistics, communication and social mobilization, monitoring, and supervision of CH activities. Also, delays in disbursement of payments to NGOs as well as for CHWs payments were also mentioned by stakeholders.	• The CHP budget, which equals **€4.5 million**, was generally considered adequate as no significant issue of inadequacy of funds was highlighted by any stakeholder. Moreover, about 3% of allocated budget was unspent (between May 2015 to May 2019). • Moreover, fund distribution appeared balanced for different programmatic components (37% for implementation by NGO's, 33% for supplies/medicines, 14% for HR costs and others). However, funds utilization was slow (8% and 9%) in first two years (2016-2017). • This finding also correlates with a slow start up of the Programme. Out of total 06 Prefectures, it took almost one year to start the treatment/curative activities by CHWs in the first two prefectures (Nana Gribzi and Ouham).
Supplies, Equipment & Logistics	• Despite the fact that most drugs were **available** in sufficient quantity, their distribution was inefficient resulting into disruption of supplies and curative interventions. One key reason was inefficient communication and coordination between various actors. • Programme procured and provided adequate number of essential logistic means for field staff such as bicycles for CHWs and motor bikes for supervisors. However, lack of adequate funds for	• Primary data indicate that necessary supplies (training materials, CHW kit items, MUAC tape, thermometer, scales, and others) were '**mostly' available**, particularly in areas where NGOs were present. • No significant issue was reported regrading availability of medicines except for malaria where shortage in some areas was highlighted by some respondents. The key issue was the irregular availability of medicines at the	• In general, material resources, medicines and supplies were **adequate** and remained available for most of the time at community care sites. In absence of a national supply system, most stakeholders praised UNICEF efforts in operationalizing an optimum supply system for distribution of medicines to remote health facilities under the Programme coverage.

	Guinea-Bissau	Chad	CAR
	repair and maintenance caused several inefficiencies in performing their role.	health centre level where frequent disruptions were highlighted (national level stock outs of medicines and vaccines were reported during 2018-2020 mainly due to administrative issues at the district level). Most stakeholders considered logistics support 'inadequate'.	• The Programme provided computer accessories generators, and motorcycles at 9 health districts to enable data entry and reporting, and to support the supervision function. A key issue was the mobility of CHWs which were not provided any transportation mean. Instead, they were provided daily subsistence and travel allowance for attending monthly meetings at health centre or at health district level.
Cost per Beneficiary	• The (actual) cost per beneficiary (for complete package delivery for two years) equals **€367** ($441)[118] in comparison to the planned €161 ($194) cost per beneficiary, indicating inefficient implementation. • The analysis is constrained due to unavailability of breakup of the total planned budget and the actual expenses for each of the five Programme components or type of interventions.[119]	• For CBVP, iCCM, 1000days and integrated package, the cost per beneficiary varies between **$0.2 to $1.7** and appears to be cost-efficient. The cumulative cost per beneficiary for all CH approaches is between $1439 to $1646. However, due to significant variations among type of CH packages or interventions, no meaningful comparison is possible on cost per beneficiary[120]. Given that the implementation of CH approaches is relatively more recent than in the two other countries, the initially upfront costs make the interventions more expensive (such costs tend to decrease over time).	• The overall cost per beneficiary (after CHW services in 36 months) against two key interventions (total household visits, and all treated cases) equals **$18**. Due to variations in the type of community health package and interventions across different countries, no meaningful comparison and conclusive judgement on efficiency of cost per beneficiary is given. • Integration of CH package to include promotion of EFPs with integrated case management of the 3 main diseases and acute malnutrition may help in reducing the overall cost per beneficiary. • The engagement of community-based women groups for promotion of EFPs will complement the CHW role and will lead to relative

[118] https://www.xe.com/currencyconverter/convert/?Amount=367&From=EUR&To=USD (02.03.2021)
[119] In lieu of these limitations of this analysis, readers are cautioned to take this analysis only as a proxy or an estimated indication of the possible cost incurred against each type of interventions. Also, this analysis does not provide insights to saved cost per family per episode of disease or in terms of QUALY or DALY
[120] The available data mentioned 129$ for household visits, 203$ per child for CMAM package; 8$ for B.P care by CHW)

	Guinea-Bissau	Chad	CAR
			reduction in in overall cost per beneficiary.
Human Resource	• The **inadequacy of HR** and their limited technical capability remained a challenge for the Programme during implementation of CH activities. All stakeholders frequently mentioned the low technical skills of most human resources at varied levels (regional health teams, health technicians at health area level, and CHWs at community level), to perform their role and functions.	• Most of the stakeholders shared a common view that implementation of all CH approaches has **faced human resource constraints** in terms of inadequacy in number and for having low technical skills. Most Govt. officials do not have strong technical skills of planning and implementing CH activities. • At policy level, monitoring of CH activities is to be done by government. However, this remains the most negatively affected activity due to the inadequacy of health staff at district and health facility level. Another key issue is about the frequent changes of senior govt officials which often contributes to delayed decision making around planning or execution of activities (implementation inefficiencies.	• The Programme was managed with **inadequate number of human resources** at MoPH level, as well as at regional and health district levels. Limited technical expertise within the available human resource created the need to hire external consultants and for UNICEF to handhold implementation led by stakeholders (including MoPH and I/NGOs).

	Guinea-Bissau	Chad	CAR
Time related inefficiencies	• During CHP implementation, various **delays** were noted in accomplishing the planned activities. For instance, the contracting with IPs was delayed (due to complex negotiations around co-financing options by IPs) and resultantly the implementation period for various IPs and in different regions varied from 14 to 27 months. Also, delays in timely refilling of stock of medicines for CHWs and delays in disbursement of payments to CHWs which led to 'demotivation' among CHWs and resulted in late submission of field reports as many CHWs withheld their reports until receipt of their payment. • Monthly/quarterly Coordination meetings were delayed due to health sector strike at national and regional levels.	• Discussions with NGOs staff highlighted that implementation time was **'insufficient'** (short contract durations with NGOs) to achieve the desired results and for transferring skills to Government. Moreover, various instances of operational inefficiencies are evident in terms of delays around activities such as delayed distribution of motorcycles, training of CHWs121 under CFC/RT, rescheduling or abandoning of vaccination activities due to health sector strike, disbursement of CHW payment122, coordination and monitoring, quarterly review meetings.	• Initially, the Programme lacked a documented workplan for implementation, therefore implementation remained evolving for prioritizing and sequencing of activities until an action plan for policy development was developed. Moreover, the implementation **remained slow** and faced various delays due to lack of normative documents at the beginning, prolonged political transition from mid-2015 to March 2016, lengthy administrative and approval procedures at MoPH, weak technical capacity of MoPH, and insecurity. All these delays led to a no cost extension for additional 12 months without making any changes in targets.
Possible alternate strategies	• A general perception prevailed among most key informants that IPs led implementation is an expensive option. They suggested working directly with the government (Health Technicians as field supervisors) could have significantly reduce the implementation costs.	• Some suggested alternative strategies for cost-reduction are a) the added focus on integration of activities; b) digitalization of data collection and transmission by CHWs; and improving the electronic system for CHW payments.	N/A

Box # 7: Preliminary Conclusion – Efficiency

1. **EFY#1 -** Across three countries, the efficiency analysis faced constraints in terms of required documentation (limited financial data, lack of disaggregated data around programmatic components, inconsistency of the available data). However, to the extent possible, the evaluators used all available financial data and triangulated it with qualitative evidence to offer these conclusions. The Programme implementation is concluded as partially efficient for not fully achieving the intended results. For GB, only 20% of the activities could be implemented, whereas for CAR only 27% treatment

[121] The training of first batch of 88 CHWs was conducted in Sep 2019, and for remaining 304 CHWs, it was planned in Dec 2019 (until this report, no evidence available on its execution).
[122] Delayed submission of reports by CHWs, to get required approvals and inefficient electronic system for payment transfers).

Box # 7: Preliminary Conclusion – Efficiency

targets (whilst using 97% of allocated funds) could be achieved. For Chad, the efficiency analysis remains incomplete for data gaps. In most countries, the host governments did not put in the contributions they committed to.

2. **EFY#2 -** On availability of resources (funds, supplies, HR), funds inadequacy is clear for GB and Chad whereas for CAR funds were considered adequate by most stakeholders. On human resources, situation is alike in 3 countries where CH interventions and approaches were implemented with minimum of resources as well as low-to-moderate technical capacities of the Government staff as well as of NGOs and UNICEF (specifically in CAR). These constraints had contributed to various operational inefficiencies (weak coordination, monitoring and supervision of CHW activities, low quality, and incomplete data collection on CH). On availability of medicines and supplies, although the situation in CAR was relatively better than in GB and Chad, instances of shortages of some medicines (ORS, Zinc, paracetamol, antimalarials) and supplies (office items, fuel for generators, repair, and maintenance of motorcycles) were recorded in all 3 countries. The implementation in all three countries is marked with slow onset, contractual issues in management of NGOs and delays in implementation of different activities (due to both internal and external factors) which has contributed to multiple contracts with NGOs (GB), varied implementation duration for different CH approaches (Chad) and seeking no cost extensions (of 12 months) in CAR. Although implementation through NGOs was considered necessary (due to operational capacity gaps within public sector) and was appreciated at most times by stakeholders, it was regarded as an expensive strategy at the same time. Moreover, the digitalization of CH data collection and transmission, as well as the lack of integration (GB, Chad) or need for more comprehensive CH Package (CAR) were regarded as an alternative approach to achieve better cost savings for similar results. Following are specific conclusions on efficiency in each of the three countries:
3. **EFY#3 - Guinea-Bissau:** Based on the variance analysis (25% of the total budget was unspent possibly due to late contracting with IPs), financial resources appeared adequate. However, most stakeholders including UNICEF staff regarded it as inadequate. Around supplies and logistics, the forecasting and distribution system was inefficient which resulted into supply disruptions at various occasions. Also, inadequacy of funds for repair and maintenance of motorcycles and bicycles for supervisors and CHWs caused various operational inefficiencies (CHWs absenteeism from monthly meetings, and low number of referrals). Moreover, contracting with IPs was inefficient, the planned Programme duration could only be implemented in 02 (Biombo and Cacheu) of 11 Regions. For 06 Regions the implementation period was almost half of the planned duration (27 months). This also explains under achievements of results for various output indicators and delayed and partial implementation of the exit plan. The Programme was managed with inadequate human resources at Regional and health area levels. The ratio of supervisors to CHWs hampered efficient delivery. The NGO led implementation proved to be an expensive option. Increasing the Government role in implementation may save HR costs significantly.
4. **EFY#4 - Chad:** The efficiency analysis of the Programme in Chad remains inconclusive due to data limitations. Drawn from qualitative discussions with stakeholders and referring to partial achievements of the CH approaches, the overall funds availability is concluded as 'inadequate' both on the part of donors and for lack of public funding for CH. On distribution of funds, no conclusive argument is drawn for the reason that few respondents considered it 'balanced', but for most respondents, funds for logistics, repair maintenance and for advance or mobile strategies were not sufficiently allocated. The implementation was partly inefficient due to inadequacy of human resources coupled with inadequacy of funds. The monitoring and supervision of implementation was affected the most due to inadequacy of human resources at Regional and health area levels. Planning and initiation of different interventions appeared less efficient as implementation timeline significantly varied from the planned timeframe for different interventions.
5. **EFY#5 - CAR:** The Programme is concluded as 'Partially Efficient'. The Programme provided adequate funds for implementation as almost 3% of the total budget remains unspent. In terms of material resources, medicines and supplies were adequate and remained available to most of the care sites. a more comprehensive integrated package (inclusion of mother health indicators, promotion of EFPs through women groups and community participation) could have increased the number of programme participants by engaging pregnant and lactating mothers without much additional costs.

4.2. Sustainability

This section describes the findings on the results or benefits of the intervention that are likely to continue after the end of the Programme.

EQ6. To what extent did Programme remain successful in designing and implementing strategies for sustainability and replication vis-à-vis governments, other partners, and communities?

EQ6.1: To what extent CH Programme manage to plan and implement mechanisms (strategies and procedures) for continuity of the interventions without UNICEF or donors support (by respective governments including high investment interventions)?

Delivery of drugs and small materials for a community care site in Baoro in front of the whole community

The key findings on sustainability assessment for each country are as follows:

4.4.1. Types of Sustainability Strategies & Implementation

GB: Desk review and discussions with stakeholders indicate that a 'Draft Transition Plan' was developed during CHP implementation as part of an exit strategy. The review of the plan indicates that the latter duly considers the current Government's capacities (technical and financial) and provides a stepwise approach for a smooth transition of CH duties and responsibilities to in-country institutions (by also focusing on a systematic skills transfer) so as to enable implementation without international NGOs support in the future. However, the plan could not be fully implemented during the Programme implementation.

Chad: The literature review points to the absence of any clearly articulated 'Exit Plan' or 'Transition Strategy'. Primary data indicates that various strategies and interventions (such as capacity building, active community participation, adequately motivated CHWs, the coordination between multisectoral platforms and local authorities, and income generation activities) were actually considered for sustainability. However, the execution of some of these activities was either weak or could not be initiated. As a result, the achievements made on the ground are less sustainable than expected. The 'institutionalization of community health' certainly remains a viable strategy at the country level as demonstrated by the creation of a separate directorate for community health within MoPH CH in 2018. However, no further details are available on the specific details on its organogram or the effective state of its functioning.

CAR: Findings from secondary and primary data analysis do not indicate existence of any clearly articulated 'Exit Plan' or 'Transition Strategy' to layout the transition of CH responsibilities from donors and NGOs supported implementation to the government counterparts. Regardless of the absence of an exit plan, some key sustainable strategies have been envisioned, including the institutionalization of community health, capacity building of health staff, and the promotion of community participation in the health domain. Some illustration of that is the development of some essential documents, such as a CH implementation guide, the CH Policy introduced in 2019, CH training materials, and other monitoring and reporting tools, duly validated by MoPH.

4.4.2. Government Ownership, Capability and Funds Mobilization

GB: As a reflection of GoGB's commitment, a CH focal point has been appointed at the regional level. At the health area level, the GoGB is in process of transferring the responsibility of CHW supervision from the NGOs to a designated health technician for each area. All stakeholders concurred that the GoGB lacks the necessary administrative and financial capacities to implement CH at a larger scale. Nevertheless, the MoPH has committed to create a budget line for CH while the Regional CH Directorates have committed to prepare annual budget for CH implementation as part of transition process.

Chad: Despite the fact that community health is a registered priority for government (as reflected by national health polices and strategic plans), all stakeholders and public officials agree that the MoPH/Government lack technical, human, and financial capacity to implement CH on its own. Additionally, the Government is not funding any of the CH activities. This is partly due to reduction of public expenditures for health sector in 2018 as they have gone down to 4.1%.

CAR: The Programme contributed to develop Government's commitment and ownership of CH interventions which is reflected by development and validation of CH implementation guide, National CH Policy 2019, and relevant training materials. There is a need to develop CH standards and a multi-year CH Plan or implementation strategy to further strengthen the institutional framework for scaling-up of community health across the country. Currently, the Government is not funding any CH activity and is reliant on external financial support.

EQ6.2: To what extent Programme activities that have been replicated by other stakeholders?

4.4.3. Replication of Community Health by Government, Partners & NGOs

GB: Discussions with stakeholders (Government, IPs, and UNICEF) do not indicate the replication of similar CH interventions by any other specific partner. Stakeholders stated that CH is a national strategy which is followed by all players in health interventions. Some examples include: i) Plan International's

work on health and WASH (beyond this project) where it has deployed CH agents for promotion of WASH and health messages at community level; ii) UNFPA is implementing various health initiatives around increased availability and use of integrated sexual and reproductive health services(including family planning, maternal health, and HIV)[123], but not as an exclusive Programme on CH; iii) UNDP with support from Global Funds is supporting GoGB in implementing a national programme on prevention of Malaria.

Chad: Secondary and primary data does not point to GoChad being able to replicate or scale-up any interventions implemented by UNICEF and NGO partners. Likewise, there is limited evidence to suggest that other development partners have been able to replicate or scale-up the CH approaches that were piloted by UNICEF and other partners.

CAR: Before the CH Programme, UNICEF tested C-IMCI approach in Nana-Mambéré in 2012-2013 (the activity was replicated in several prefectures by other international NGOs such as the Mentor Initiative, IMC, etc.) As part of implementation of the current Programme, UNICEF conducted mapping of NGOs and other partners operating in the target areas to inform them about the programme.

EQ6.3: To what extent the Programme implementers and communities willing and capable to sustain practices for maintaining health status as per (WHO/UNICEF and National) recommended practices for disease control particularly for U5?

4.4.4. Community Willingness and Capabilities

This sub-section highlights sustainability[124] prospects in each country with respect to community's role and capacities.

GB: Community awareness of a few practices pertaining to mother and child health care (pre-post-natal care, breastfeeding, prevention of malaria and diarrhoea) has increased and is likely to benefit communities in future. The discussions with health technicians and community members indicate that communities now understand the importance of preventive behaviours and are likely to continue with their improved behaviours. However, most respondents believe that in absence of CHWs' routine visits to households, it is likely that community practices on disease prevention and curative practices will diminish in the long run.

Chad: Filed level discussions and evidence indicates that about one fifth of communities in targeted areas will continue the newly learned practices while others will neglect them. If the community decides to come together to make savings it can continue few small-scale interventions (to support CHW by income generation activities) but not major interventions. However, most respondents believe that it will be difficult for communities to continue such role external support by government or NGOs.

CAR: All community care sites were established after consultation and willingness of targeted communities. Multiple stakeholders highlighted that communities are not capable of supporting CHWs with any financial incentives. As per the CH Programme progress report, given that only about 20% of the targeted communities were supportive to CHWs through in-kind support, it can be inferred that at best, only this portion of communities will be willing to support CHWs or CCS functioning. Community level discussions show improvement in mothers' knowledge of how to treat simple cases of the three most common diseases affecting children under five. Since no internal behavioural assessment was conducted during implementation of the Programme, evaluators are unable to comment on the extent of behavioural change in communities.

Box # 7: Preliminary Conclusion – Sustainability

1. **SUS#1 -** In all three countries, CH Programme and approaches have weak sustainability prospects for various reasons mainly due to reliance on donor support, limited technical and financial capacities of public partners and limited capacities of communities to support CHW work and CH interventions. In Chad and CAR, a clear 'exit plan' or 'sustainability roadmap' was missing, whereas in GB a 'transition plan' was developed during CHP implementation but could not be implemented fully.

[123] https://www.unfpa.org/data/transparency-portal/unfpa-guinea-bissau
[124] EQ6.3: To what extent the Programme implementers and communities willing and capable to sustain practices for maintaining health status as per (WHO/UNICEF and National) recommended practices for disease control particularly for U5?

Box # 7: Preliminary Conclusion – Sustainability

Furthermore, neither the government nor the partners have clear intent for implementing CH approaches on a larger scale in future. In terms of increased Government' ownership and commitment, some notable achievements are evident in GB and CAR (especially on the CH institutionalization front), whereas GoChad is far behind in taking concrete actions to support CH implementation. Following are specific conclusions on quality of engagement and contributions of partnerships in each of the three Countries.

2. **SUS#2 - Guinea-Bissau:** The key achievements that bode well for sustainability include: i) appointment of CH Focal Points at Regional Health Directorates (RHDs); and ii) the designation of health technicians at health area levels with CH supervision role. However, in comparison to the NGOs payment structure, the compensation for health technicians has been regarded as quite low, especially in view of the additional role attributed to them, which eventually led to a certain degree of demotivation. Likewise, the difficulties in maintaining balance between the regular activities and the ones associated with the additional role were described as key challenges to the achievement of sustainability in the medium- and long-term. With respect to the availability of a 'transition process or exit plan', it will take time to transfer 'necessary skills' and develop the 'appropriate implementation capacities' within RHDs. In order to enhance CH sustainability, the UNICEF GBCO is making efforts to mobilize resources for future rollout. In parallel, uncertainties exist in fund mobilization from the existing partners (the WB and EU). Therefore, the evaluators may conclude that, despite few preliminary successes towards transitioning of implementation from NGOs to the Government, the GoGB is certainly not likely to be able to continue CH interventions without external support.
3. **SUS#3 - Chad:** All CH approaches lacked focus on developing 'exit plan' or sustainability strategies. Few sustainability strategies *(capacity building, active community participation, adequately motivated CHWs, the coordination between multisectoral platforms and local authorities, and income generation activities)* that were envisioned at design stage, could not be fully implemented. Eventually, the achievements are less sustainable. On sustainability prospects, the restructuring of CH directorate and the availability of essential key documents represent some key achievements towards the CH institutionalization and are likely to be sustained over time. To the contrary, all other key strategies *(capacity development of health providers, community participation, package of CH services, and monitoring and evaluation of CH)* are less likely to be sustained without donor support and NGOs presence. Beside the fact that Government views CH as its priority, no practical actions have been taken to mobilize public funds for CH, the most critical prerequisite for attaining sustainability. Also, uncertainties exist around availability of donor funds for CH.
4. **SUS#4 - CAR:** Despite a lack of sustainability strategy or exit plan, the Programme has contributed to achieve some level of CH institutionalization, by developing minimum necessary public sector capacity to implement CH interventions in the country and attaining Government's strong commitment to and ownership of CH interventions at the highest level in the MoPH. However, the country still does not have either CH standards or a multi-year CH Plan or implementation strategy to further strengthen the institutional framework for scaling-up of community health across the country. Also, various administrative (Government led permanent implementation arrangements are not in place for CH) and operational constraints (unavailability of trained nursing supervisors in several health centres, continued procurement and availability of medicines, unavailability of country-wide national supply system) are still there. Moreover, the unavailability of a budget line for community health remains a challenge to sustaining the CH interventions or the results thereof. Eventually, the MoPH is fully dependent on continued external support, both technical and financial.

4.3. Gender Equity, Human Rights and Equity (Non-DAC Criteria)

This section presents findings on integration of UNICEF's cross-cutting priorities (referred to as non-DAC criteria) comprising gender equality, HRBA and equity. There is one key evaluation question with three sub-questions.

Q7. To what extent did CH Programme (CH approaches/strategies) design and implementation integrate principles of gender equality, human rights, and equity?

EQ7.1 (Gender Equality): How successful was CH Programme design and implementation to integrate, implement and monitor (results) gender equality principles and approaches and what type of barriers that prevent girls and women's access to CH services were fully or partially addressed?

EQ7.2 (HRBA): How well did Programme design and implementation integrate HRBA principles (Participation, Accountability, Non-discrimination and Equality, Empowerment and Legality)?

EQ7.3 (Equity): How successful has Programme design and implementation (including monitoring) been to identify and target the most vulnerable groups with appropriate services?

Children washing hands from water source provided by UNICEF Chad/2018/Sangmooh Han

The findings below cover assessment of gender equality integration at design, implementation, monitoring and reporting of results.

4.5.1. Gender Equality

For this sub-question, gender equality is assessed at: i) design and implementation; and ii) monitoring and reporting levels. The findings have been drawn from secondary and primary data (collected through KIIs, FGDs and reflection workshop) for each one of the three countries covered by the evaluation.

	Guinea-Bissau	Chad	CAR
Integration of Gender Equality into design and implementation	• The programme design was not informed by a gender assessment but offers reasonable level of gender integration. All stakeholders stated that throughout the implementation, the optimum (or a 50/50 balanced) ratio of female to male CHWs could not be attained mainly due to non-availability of women in the remote communities with required minimum education (4th grade) to be eligible for CHW. • Discussions with IPs did not highlight any prioritization or focus on hiring female 'supervisors' for female CHWs. Moreover, the ratio of male to female supervisors was low (qualitative assertion), but not documented.	• The Programme design was not informed by a formal gender assessment. • The design and implementation of all CH approaches (CBVP, CFC/RTM, 1000 days for malnutrition and ICCM) indicate due focus on gender integration. • The evidence includes women participation in care groups (1000days approach) for awareness raising, and involvement of women in multi-sectoral forums which were established at community level (CFC/RTM), recruitment of women as CHWs/CRs (though remained limited), household visits by CHWs for interpersonal communication and health counselling with pregnant women. • All these interventions aimed to address key gender barriers (knowledge gap, distance, cost). However, contributions of CH approaches are insignificant in addressing the cultural barriers (husband and family preferences, myths about health issues). Some weak aspects of gender integration included the following: inconsistent application of paired deployment of CHWs, low ratio of female CHWs at 20-30%, relatively low technical capacities of female CHWs). Also, gender integration into monitoring and reporting was not prioritized. The targets and results were not disaggregated for boys and girls.	• The programme design was not informed by a gender assessment and the review of Programme logframe/results framework does not indicate any specific strategy to promote gender equality. The expenditure analysis does not indicate any gender specific allocation or expenditures. Children under five remain the key focus of the Programme, thus indirectly benefitting mothers by improving their quality of life in terms of reduced morbidity among children. • The Programme could not engage women groups for their role in sensitization on EFPs, and around developing IGAs due to unavailability of Government approved guidance document on their selection.

	Guinea-Bissau	Chad	CAR
Gender Integration into Monitoring and Reporting	• Although at design level, the description of interventions mentions gender disaggregation for boys and girls, **monitoring and reporting** do not indicate gender disaggregation for boys and girls. Also, CHWs faced difficulties in data collection and reporting because the Creole (local language) is exceedingly difficult for common people to read or write.	• Limited evidence is available to indicate **monitoring and reporting of data separately** for boys and girls. Reporting is mostly done for children (ignoring disaggregation by sex).	• **The target setting and reporting of results do not indicate the separate targets or results for boys and girls.** However, monitoring reports indicate tracking of separate results for boys and girls.

4.5.2. Integration of Human Rights-Based Approach (HRBA)

Following is the evaluation team's assessment on Programme's (for each country) compliance to HRBA principles:

	Guinea-Bissau	Chad	CAR
Participation and inclusion	• Discussions with stakeholders endorsed that the CHP encouraged participation of duty bearers (RHTs, staff at health area and at facility; also, IPs) for their role in implementation. • For the right holders, their participation is only limited to getting CHP services directly or indirectly. The participation of general community is not visible. The CHP promoted the inclusion of local people to become CHWs	• As right holders, the participation of women and men (as part of care groups) was well-acknowledged by all stakeholders. • The inclusion of local people to become CHWs was promoted. Involvement and participation of local authorities, community leaders and health staff (duty bearers) remined weak (CFC/RTM, ICCM, CBVP). • Participation of general community was not visible.	• **Programme design and implementation reflects HRBA integration by offering participation opportunities to duty bearers** (CH Focal points, staff at health district and at facility level), **implementing partners and right holders.** • The CHP promoted participation of indigenous people (remote communities with low education profile) to become CHWs.

	Guinea-Bissau	Chad	CAR
Accountability[125] (and Transparency)	• Community level discussion**s** d**id** not point to the existence of any formal complaint mechanism. • The feedback mechanisms or exchange of programme information and data (progress and results of CH activities) between service providers (health facility staff, and CHWs) and communities (as right holders) was not evident.	• In CFC/RTM, the social accountability was promoted to oversee the activities of multisectoral platforms. A community-based grievance redressal mechanism was effectively operationalized to respond to community feedback. • All stakeholders consistently highlighted the lack of accountability culture within **government which weakened the** supervis**ory role of it**.	• **Community level discussions did not point to the existence of any formal complaint mechanism for parents.** • The involvement of Minister of Health in Programme activities helped enhancing accountability within related officials of MoPH. • The reporting of results around duty bearers (or service providers) is not adequate (e.g., exact number of MoPH officials benefitted from training is not documented).
Non-discrimination and equality	• All KII respondents (public officials, IPs, UNICEF) mentioned that the Programme does not discriminate in any manner while engaging with duty bearers. • All stakeholders shared that the CHP equally treated all right holders (specifically pregnant and lactating women and children) without any discrimination (based on race, colour, ethnicity, age, sex, disability, income, language, religion, nationality, property, birth, or other factor. • Some right holders (pregnant women and children U5) could not take benefit from the Programme due to lack of transport, non-availability of medicines and/or strike of health staff.	• All KII respondents (public officials, IPs, UNICEF) mentioned that the Programme does not discriminate in any manner. • All stakeholders shared that the CHP equally treated all right holders (specifically pregnant and lactating women and children) without any discrimination (based on race, colour, ethnicity, age, sex, disability, income, language, religion, nationality, property, birth, or other factor. • Some right holders (pregnant women and children U5) could not take benefit from the Programme due to lack of transport or due to non-availability of medicines or due to strike of health staff.	• All KII respondents (public officials, IPs, UNICEF) shared a common opinion that the Programme does not discriminate (due to any factor such as ethnicity, age, sex, disability, language, religion, birthplace, or any other factor) while engaging with duty bearers and right holders or beneficiaries. The Programme treated all sick children equally without any discrimination.

[125] Accountability: 'the duty-bearers are held accountable for failing to fulfil their obligations towards rights-holders. There should be effective remedies in place when human rights breaches occur'. Transparency: 'all means of facilitating the citizen's access to information and also his/her understanding of decision-making mechanisms'

	Guinea-Bissau	Chad	CAR
Legality	• The CHP followed and adhered to all national and international laws and policies to deliver community-based health services to its population (the right holders). • Although the GB Constitution is not explicit to the right to health, the Article 29 requires that fundamental rights must be interpreted in harmony with the Universal Declaration of Human Rights, which recognizes the right to health in article 25.[126] • Government being signatory of CRC, and Regional Compact etc., requires attention to mother and child health.	• Community participation is advocated by the Govt. of Chad to fulfil its international commitments under *'Alma Ata's 1978'* declaration around "health for all by the year 2000" and to 'Bamako initiative 1987', and others (CRC, Regional Compact). • The CH approaches are supported by 3 key legal provisions *(Order No. 003 / MSP / DG / 94; b) Law 019 / PR / 99 and c) Decree No. 364 / PR / MSP / 2001)* around community participation. • Health Committees (COSAN) and Management Committees (COGES) are responsible to support health services delivery.	• The CHP roll out adhered to all applicable national and international laws and policies to deliver its services. • The CAR Constitution (2016) - article#8 grants right to health to all persons. The Programme respond to various public health laws (Act No. 89.003 of 23 March 1989 and others) in the Country. • The Programme contributes to Government's efforts to comply with various international commitments (UN CRC, and Regional Compact "Key Results for Children" etc.), for focusing on mother and child health.

4.5.3. Integration of Equity

This section explores how equity was ensured at Programme's design, implementation, and monitoring[127] levels.

	Guinea-Bissau	Chad	CAR
Equity Integration into Design and Implementation	• Evidence suggests that a formal vulnerability need assessment was not conducted at the design stage. • The CHP design was informed by multiple situation analyses (Health Sector Plans I & II) and national surveys (MICS 4 & 5). As part of implementation, the CHP conducted local census or village level mapping through CHW and health staff to identify and estimates the number of target beneficiaries.	• At design level, all approaches were equity focused as the primary beneficiaries of all approaches were women and children who are generally regarded as the most vulnerable groups of population. The CH approaches, to some extent, attempted to reach and benefit to nomads, and refugees as they are	• The review of the Programme documents does not provide any evidence of need assessments undertaken to inform the design. The Programme design was informed by using secondary data available in Health Sector Plans II, HeRAMs and national surveys (MICS 5 & 6). Design-level equity focused considerations include the inclusion

[126] https://uniogbis.unmissions.org/sites/default/files/report_on_the_right_to_health-_guinea-bissau_english_.pdf
[127] EQ7.3: How successful has Programme design and implementation (including monitoring) been to identify and target the most vulnerable groups with appropriate services?

	Guinea-Bissau	Chad	CAR
	• For equity integration, the 'vulnerability' is defined as 'anyone living outside 5KM from the health facility', and specific strategies to reach remote populations (mobile strategy for population within 5KM, and advance strategy for populations living at more than 25KM) were implemented accordingly. This also covers most difficult to reach areas such as island areas to provide services. • At implementation level, The CHP provided 'free medicines' to treat children (sick with diarrhoea, and pneumonia) and promoted the availability of 'free health services' particularly for children pregnant and lactating women and children (through facility-based services of PIMI-II). Therefore, the needs of economically excluded groups were addressed to some extent. Moreover, by taking health services to their 'doorstep', attempt was made to reduce the travel cost and save traveling time. • The CH services were offered to all population groups without discrimination (including the migrants and people living on islands) reflecting the focus on integration.	considered most vulnerable in Chad context. • During implementation, few interventions were implemented that highlight the equity focus, on the following a) vulnerable groups identified and supported to start some IGA under CFC/RTM and 1000 days approach; b) poor pregnant women who were provided with local transportation means (carts) to access services in emergency situations; c) local people involved in community-based multi-sectoral forums; and d) Mother's groups to reach those pregnant women who were difficult to reach by male workers. • Equity focus was undermined in some situations, for instance, advance strategies for most remote communities and nomad population groups (living far from towns) could not be executed.	of Prefectures (Bamingui-Bangoran and Haute-Kotto) that remained isolated and deprived from basic social services due to armed conflict since 2012; and establishment of community care site with 15 CHWs in one IDP camp (Fulani - Zaligo) in Nana-Membrane. • As part of implementation, the CHP conducted situation analysis in the targeted areas to identify the eligible communities for establishment of care sites and estimate the number of children under five years of age. This assessment used an equity focused criterion for selection of communities (10km away from health centre). • The equity focus was diluted in certain situations as some communities could not be reached due to armed conflict and political instability. Also, the Programme had weak focus on preventive measures for pregnant and lactating women.
Equity into Monitoring and Reporting	• The monitoring indicators and tracking of activities and results are disaggregated by age, type of interventions, and status of women in childbearing aged 15-49 years (# of pregnant women, # of HHS visited by CHWS; # of children U5 treated for 03 diseases, malnutrition (SAM) and Vitamin A for 6-59 months, Deworming 12-59 months; and distance of remote communities). The monitoring and reporting on other vulnerability criteria (disability, poverty, education, ethnicity,	• There is limited evidence to indicate disaggregation of results for children (by age and sex of children) and for pregnant and lactating women (by other equity parameters such as rural/urban status, and education or others.) • The monitoring of activities and tracking of progress or results for various vulnerable groups (single	• The monitoring of activities and tracking of progress incorporates the equity perspective by presenting disaggregated information by age of the child, type of interventions (treated or referred) and type of 3 diseases, malnutrition, and screening of children for Vitamin A supplementation (for children 6-59 months) and immunization status (0-11 months). The monitoring and

	Guinea-Bissau	Chad	CAR
	single mothers) was not considered. All targets were set at national level and Region level targets were not defined.	mother, disabled, refugees, nomads, and poor) was not prioritized. •	reporting on other vulnerability criteria (disability, poverty, education, ethnicity, single mothers) was not considered.

Box # 7: Preliminary Conclusion – Gender Equality, HRBA and Equity

1. **Gender Equality (GE#1):** Across all countries, no gender specific assessment was undertaken to inform the Programme design. Despite this all, CH interventions and approaches are assessed as gender sensitive. The evidence includes as the CHP and approaches offered opportunities to eligible women to become CHWs, encouraged women's participation through community-based groups or forums, and provided training to CHWs – which benefitted female CHWs more (than male CHWs) to improve their social status and wellbeing. At implementation level, a mix of gender responsive strategies were implemented across three countries, however their success and contributions to address gender barriers (knowledge gap, lack of access due to long distances, and cost implications for seeking health care etc.) mostly common in all 3 Countries, remain insignificant. Despite the noble intentions of all CH approaches to attain optimum or equal ratio of female CHWs, the female participation as CHWs in all 3 countries remain inadequate (GB 21%, Chad 20-30%, and CAR 34%). Some key overlapping reasons for low female participation include a) the low literacy among rural women in remote communities; b) the lack of decision-making power among women, in that such power usually rests with husbands or fathers; and c) permission restrictions to go out or pursue a job.
2. **HRBA (H#1):** Across all countries, the Programme's design and implementation is assessed as mostly compliant with HRBA principles. Participation of duty bearers and right holders was encouraged at the design level and during implementation. One weak element, common in 3 Countries, is inadequate community participation except communities' role in identification of CHWs. In GB and Chad, no specific interventions were visible to encourage community participation whereas in Chad, under CFC/RTM approach, multisectoral forums at community level provided this opportunity to communities. Various other interventions (baby friendly mothers' group under 1000 days approach in Chad, involvement of women headed CBOs and mothers' groups in CAR) could not be fully implemented or initiated. On the accountability front, the situation is pretty much the same across the three countries and features weak accountability culture within public sector and non-existence of complaint mechanisms at community level. The compliance to other two key aspects of HRBA (i.e., non-discrimination, and legality) is 'mostly' visible in all CH interventions across three countries.
3. **Equity (EQ#1):** Across all countries, equity integration is visible at the design level. However, during implementation, the compliance remained 'partial' to equity considerations. Regardless of the scale and coverage, in each country, there are few strategies or interventions which demonstrate adherence to equity (such as prioritization of remote communities, provision of free medicines and services for all groups, execution of mobile strategies to provide services at the doorstep in remote/isolated communities, baby friendly mothers groups, and income generation activities though under CFC/RTM). However, with varying degree of the effects, various operational constraints (lack of funds, logistics, weak coordination, and shortage of health staff, conflict, insecurity, and others) have dented the intended outcomes of benefitting all vulnerable groups. The equity integration into monitoring, data collection and reporting of results for vulnerable groups (single mother, disabled, refugees, nomads, and poor) remained weak and partial across three countries. In relative terms, the equity focus is more visible in GB, than in Chad, and then in CAR.

Chapter 5: Conclusions, Lessons Learned and Recommendations

This chapter presents the synthesized or consolidated evaluation conclusions, lessons learned and recommendations. The description outlines those applicable across the three countries (focused for evaluation) and where needed the outliers are highlighted as such. The description relies on the comparative analysis of three country reports. The contents and presentation of this chapter is driven by the purpose behind the regional report and meet the expectations of the readers or users.

5.1 Conclusions

Find below the conclusions structured as per the DAC and Non-DAC criteria. Additionally, for each country a para is added towards the end outlining conclusions around the way forward for the intervention.

Relevance

- At macro level, the CH programs and interventions are concluded to be relevant to the context or needs on the ground. The three countries appear to have the highest child (U5) mortality rates (89/1000 live births in GB, 133/1000 live births in Chad, and 130/1,000 live births in CAR in 2014-15)[128]. Moreover, due to the fact that the interventions prioritised the provision of services associated with the three most lethal diseases for children (diarrhoea, malaria, pneumonia), the CH programs and approaches under evaluation are responding to the need for lowering the child mortality rates (amongst the highest in the world) in the three countries where they are implemented.
- The CH programs and interventions are concluded to be relevant for addressing the critical systemic issue of inaccessibility to the healthcare staff and facilities. In particular, the outreach model applied via trained CHWs for preventive education and identification, treatment, and referral of disease/s, look appropriate in contexts with poor health coverage.
- The CH Programs and interventions are concluded to be well aligned to the national health policies and plans, particularly with respect to the objectives and strategies. Moreover, the activities and strategies on the ground appeared to be largely compliant with both national and international guidelines (particularly of WHO guidelines on CH Programme and policies)[129] and standards for community health programming. That said, there are areas (such as recruitment criteria, low ratio of female participation, partial compliance to deployment of CHWs in pairs (one male and one female), inconsistent and low level of compensation for CHWs, lack of career progression opportunities for CHWs, no formal certification system for CHWs, and limited use of IT in CH data collection and reporting) where alignment is yet to be attained.
- The design of CH programs and interventions (especially the 'hybrid' implementation approach featuring joint government- and CSO-led implementation) responds to the need for filing the systemic gaps and in-efficiencies in the public healthcare system across countries. The decision to involve CSOs (particularly INGOs) appears to have especially benefitted the CH cause.
- There is wider acknowledgement (amongst health authorities across countries) that the CH Programme and interventions has been: a) enabling (to set standards, workable models and expand outreach); and supportive of international commitments such as UHC, SDGs # 3.2, Bamako Initiative, and others.

Effectiveness

- The evaluators are unable to make a conclusive judgement on the CH effectiveness for a host of reasons, primarily related to data limitations. From whatever usable data was made available, the evaluators could argue that the CH Programme and approaches have been partially effective across the three countries. This is attributed to the fact that in Chad only 20% of the activities (planned as part of CHSP implementation) could be implemented and for CAR the

[128] 2019 Data (51/1000 live births in GB; 122/1000 live births in Chad and 99/1000 live births in CAR)
[129] WHO guideline on health policy and system support to optimize community health worker programmes 2018; https://apps.who.int/iris/bitstream/handle/10665/275474/9789241550369-eng.pdf?ua=1&ua=1; Updated Programme Functionality Matrix for Optimizing Community Health Programs (2018); https://www.unicef.org/media/58176/file

Programme managed to treat 27% of the planned cases (for three diseases). In GB, out of five intended outputs, achievements against two outputs (R1: Continued availability of essential medicines/equipment for CHW; R3: Improve quality nutrition services for pregnant and lactating women and children) are assessed as 'Partially Effective'. The other two outputs (R2: 16 family practices are promoted and strengthened; R4: Strengthening coordination and management of health activities and nutrition) are assessed as 'mostly effective'. The last/fifth (R5: WASH related capacities of communities, households, and health centres strengthened) is assessed as 'least effective'. That said, the trends in both GB and CAR, suggest reduction in child (U5) mortality rates.

- Across the three countries, the interventions have been successful in placing CH as public policy priority on the health managers' agenda. Moreover, the hybrid approach has enabled public officials to get first-hand experience of managing/contributing to CHP delivery.
- On WHO's CHW AIM Matrix, the system across three countries is concluded to be partially effective. The most systemic aspects noted to be deficient include a) the weak management framework; b) the inadequate level of community participation; c) the low degree of female participation; d) the low morale level amongst CHWs; and e) the ongoing political instability.
- The partnership with NGOs has proven effective in enabling public sector to produce some results. For most countries, the Programme faced delays on account of multiple factors such as contracting and mobilisation of partners, etc. The monitoring remained inadequate and is concluded as ineffective.

Efficiency

- The implementation of CH Programme and approaches is concluded to have been partially efficient for not having been able to fully achieve the intended results within the expected timeframe and based on the given HR capacities and good available. For Chad, only 20% of the activities could be implemented, whereas for CAR only 27% of the treatment targets (children sick and treated for 3 diseases) could be achieved despite the utilization of 97% of the allocated funds. For Chad, the efficiency analysis remains incomplete for data gaps. In most countries, the host governments did not put in the financial contributions.
- Across countries, the delivery or implemented got delayed for host of issues such as inadequate HR planning, delayed contracting (of partners) and supply chain disruptions.

Sustainability

- The evaluators may conclude that the CH Programme and approaches across 3 countries remain heavily reliant on continued support on donors and technical partners. The public sector has either limited or no funds for CH implementation. The countries have not been able to replicate or upscale the Programme at their own except the external support.
- The policy frameworks and plans are likely to stay operational over time. However, the limited public sector financing threatens their implementation. The CH Programme and approaches have contributed to developing public sector capacities particularly through the provision of training to staff within the public sector. The future implementation would remain heavily dependent on INGOs to implement together with host governments.

Gender Equality, HRBA and Equity

- The design appears to have not been informed by documented gender assessments. The interventions appear to be largely gender-sensitive for prioritising gender responsive strategies (by engaging men and women as CHP and leveraging support of or reaching out to existing community and women groups), irrespective of the successes to address gender barriers. The monitoring systems demonstrate limited integration of gender equality.
- The Programme design and implementation appear to be largely HRBA compliant i.e., with respect to the principles of participation, accountability, non-discrimination and equality and legality. Across the countries, the design and implementation of CH Programmes and

approaches merits a considered focus and improvement around accountability (by giving voice to the communities to hold public office holders accountable) and participation (engaging with community at large and in particular existing community and women groups).

- The design and implementation of CH programmes and interventions demonstrate integration of equity principle particularly with respect to prioritising far-off communities placed far away from health centres. The evaluators did note a limited focus on integrating other identity features that may affect access to healthcare such as poverty, religion and ethnicity, disability, and others. Furthermore, the monitoring records don't suggest a considered focus on keeping track of how interventions are addressing inequities and how different groups are benefitting.

5.2 Lessons Learned and Good Practices

Below are the lessons learned[130] and good practices identified during implementation of CH initiatives based on the evidence collected in the evaluation process. This section aims to leverage the experience gained in both countries to identify clues for improving relevance, effectiveness, efficiency, and sustainability for future projects in different contexts. Like the conclusions, the lessons learned are consolidated keeping in view their applicability across countries. Where required, the outliers have been referred to also. The key lessons and good practices are outlined below:

Lessons Learned

- A joint implementation approach (involving both public agencies and I/NGOs) contribute to the successful performance of a CH Programme or approaches. This is particularly deemed appropriate in contexts with limited healthcare outreach, and dearth of technical capacities and exposure to CH programming. These public-CSO partnership remains key to success in resource constraint environments – featuring limited technical capacities, funds, and outreach of public healthcare architecture.
- The engagement with local groups or committees (community committees, women groups etc) proves useful in mobilising communities, cultivate ownership and support within communities. For instance, in CAR where it was not done, the Programme did not go far in garnering community support.
- The non-acceptance of CHWs as part of the healthcare apparatus, together with and low compensations contributes to keeping the morale and motivation of CHWs low. The limited educational attainments of CHWs hinder them to understand the complexities of monitoring tools and reporting, which needs to be simplified for future.

Good Practices

- The paired deployment of CHWs (whereby men and women recruited and deployed together) proves effective in overcoming the gendered divisions and enabled access to both men and women. This warrants continuity in future particularly in socially conservative communities.
- The use of visual materials/aids for training of CHWs (mostly being either un-educated or with limited education) proves useful and effective in better understanding and internalising the related contents. Similarly, the post training follow-up (CAR) and contact with CHWs help in taking stock of localised challenges and engaging with CHWs to find and apply context specific solutions. The countries are advised to adopt these two practices for future.

[130] A Lesson Learned is knowledge or understanding gained by experience (positive or negative) that has a significant impact for an organisation. A Lesson Learned documents the experience gained during a project. http://www.nickmilton.com/2009/05/what-is-lesson-learned.html

5.3 Recommendations

The following recommendations rest on the findings and conclusions presented above. The recommendations were discussed and validated by the UNICEF Regional Staff and the detailed corresponding action will be agreed upon with several regional partners (with a vested interest in CH programming) during a validation workshop expected to take place in February 2022, which will serve as the basis for the development of the evaluation management response. The recommendations are grouped into two categories i.e., strategic, and operational, whereby each one is tagged on order of priority (short, medium, and long term) and identifies the relevant stakeholders to act (applicable across countries). *Also, each recommendation has been cross referenced and marked with the most relevant corresponding conclusions (presented in Chapter#4) under each DAC criteria* i.e., Relevance (REL), Effectiveness (EFF), Efficiency (EFY), Sustainability (SUS) and cross cutting priorities gender equality (GE), equity (EQ) and HRBA (H).

S#	Recommendations	Priority	Responsibility Primary / Secondary
	Strategic Recommendations (mostly aimed at UNICEF WCARO and its global/regional partners)		
1	**Within the ambit of enabling environment, the countries have developed and implemented CH policies/strategies (in Chad NHSP 2021-25 in Chad; and 3rd National Health Sector Plan-III in CAR, is being formulated).** These policies/strategies merit considered revisions with respect to: • Integrate CH into national health sector plans and -where needed- formulate/implement dedicated strategic plans for community health, while ensuring a multisectoral approach with Ministries of Finance, Decentralisation, Social affairs, and Social Protection. [EFF#1, 2, 6, 10], [EFY#1&2], [GE#1, EQ#1], [SUS#1-3] • Focus CH policy, strategy, and implementation on the engagement with organised community groups (community leaders, influencers, and women groups) to mobilise support, cultivate ownership and involve communities to oversee the work of CHWs. To do so, it is crucial to enroot CH programmes and responsibilities within local governance mechanisms and reinforce social accountability of all actors. [EFF#10-13] • Advocate to both national governments and global partners for dedicated and sufficient public financial allocations for CH programme scaling-up and implementation. [EFY#1-3]	Short- to medium-term	Primary Responsibility: UNICEF WCARO RO, UNICEF Country Offices Secondary responsibility: National Governments, relevant Ministries, I/NGOs, and other Development Partners.
2	**Strengthen the institutionalisation of community health programmes (in terms of technical, management and administrative aspects) and coordination capacities of relevant ministries (MoH/MoPH) at central, regional, and district levels to ensure the nation-wide implementation of CH approaches/interventions; and provide leadership and steerage to development partners through effective coordination.** The actions may include: • Assess the institutional/structural needs for CH planning and implementation at national and sub-national levels. To this end, set-up dedicated structures (and strengthen existing CH sections/units where available) with a clear definition of CH roles and responsibilities and a sound accountability framework. [EFF#10-13], [SUS#1-3], [H#1] • Improve the design, implementation, performance, and evaluation of CH programmes through the application of the WHO guidelines to optimize the performance and impact of community health workers. [REL#2], [EFF#6-10]	Medium-term to long-term	Primary Responsibility: UNICEF WCARO RO, UNICEF Country Offices Secondary responsibility: National Governments, relevant Ministries, I/NGOs, and other Development Partners.

S#	Recommendations	Priority	Responsibility Primary / Secondary
	• Harmonize existing data collection tools and reporting formats for use by CHWS and supervisors and explore digitalization options for real time tracking and performance monitoring by using the Community Health Information System guidelines and linking it to Health Management Information system (HMIS). [REL#2], [EFF#6-9] • Assess gender dimensions and undertake gender analyses to strengthen the planning of CH programmes that influence gender equality within the communities and promote female leadership and roles in the implementation of community health programmes. [EFF#6], [EFY#6-9], [SUS#1], [GE#1, H#1, EQ#1]		
Operational Recommendations (mostly aimed at the UNICEF Country Offices and their in-country partners across the region)			
3	• Re-assess and develop consensus around CH integrated package of services with a focus on keeping proven community-based interventions such as integrated case management of the three main diseases, screening and management of acute malnutrition and promotion of essential family practices. [EFF#1-5], [EFY#4-5] • Assess/pilot the integration of other interventions such as early childhood development using the nurturing care framework as an opportunity to, not only reduce child mortality and morbidity, but also to support the thrive agenda. [EFF#1-5], [EFY#4-5] • At implementation level, undertake mapping of resources and needs; recruit and deploy required staff needed to lead/assist in CH interventions, including the establishment of national master list of geo-referenced CHWs as the very first step to official recognition (and endorsement) by the MoH the assessment of training and resource needs; the elaboration of capacity development plan/s with clear targets and actions; monitoring plans; and resources. [EFF#1-5] • Support the pilot of digital data collection and use at decentralized levels. [REL#2], [EFF#6-9] • Focus the CHWs performance evaluation and quality of care (identification/screening, diagnosis, treatment, and referrals). [EFF#6-9] • Allocate 5-7% of CH resources for M&E functions and advocate for application of Results-based Management (RBM) principles and practices. [EFF#10-13] • Build on this regional evaluation (including its lessons learned) to commission country-wide CH "rapid" evaluations in the future.	Short to long-term	Primary Responsibility: UNICEF WCARO RO, UNICEF Country Offices Secondary Responsibility: National Governments, relevant Ministries, I/NGOs, and other Development Partners.
4	**Make dedicated efforts in improving the recruitment, training and working conditions of the CHWs by taking multiple measures such as;** [REL#2], [EFF#6-9], [SUS#1-3] • Offer flexible recruitment criteria for CHWs selection to attain equal or optimum ratio of female CHWs and encourage wider community participation in the final selection of CHWs by educating communities and prefer taking married people or those of above 18 years to improve CHW retention. • Define/clarify the role of community-based committees and technical health committees at HF level.	Short to long-term	Primary Responsibility: UNICEF WCARO RO, UNICEF Country Offices Secondary Responsibility

S#	Recommendations	Priority	Responsibility Primary / Secondary
	• Ensure attaining a balanced workload for CHWs in terms of allocated number of HHs and data collection and reporting requirements; offer them minimum adequate compensation (shared by community) and apply formal certification of trained CHWs to enhance their motivation. • Develop and implement a comprehensive 'Integrated Communication Plan' with focus on enhanced community participation to improve community awareness with involvement of community-based groups/CBOs for reducing the impact of cultural barriers (to use of health services) and generate demand on sensitive issues (nutrition, breastfeeding, and others). • Simplify and reduce the number of existing data collection tools and reporting formats for use by CHWS and the checklists or tools for supervisors. Ensure availability of these tools and formats in local language. This will enable CHWs (who find difficulties in data collection due to their low education profile, and multiplicity and complexity of indicators in data collection tools) to produce complete and reliable community health data at community level.		National Governments, relevant Ministries, I/NGOs, and other Development Partners.

Appendices

Please refer to the separate document containing all the evaluation report Appendices.