USAID'S HEALTH EVALUATION AND APPLIED RESEARCH DEVELOPMENT (HEARD) PROJECT

Final Evaluation of USAID/Guinea Health Service Delivery (HSD) Activity

USAID Presentation
September 15, 2020

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on behalf of the HEARD evaluation team

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Context

The **USAID/Guinea Health Service Delivery (HSD) activity** is a 5-year agreement (2015 – 2020) with a total budget of $28.8 million, which was awarded in December 2015 to Jhpiego and its partners, Engender Health and Save the Children.

Overarching Goal: to support the provision of an essential and integrated care package (EICP) for maternal, neonatal child health (MNCH) and family planning (FP) in a consistent and high-quality manner in health facilities and surrounding communities in 7 of 8 regions in Guinea.

Three Core Objectives:

1. **Delivery of quality health services improved**
2. **Healthy behaviors and demand for quality health services improved**
3. **Health systems strengthened**

Cross-cutting QI Approach: Standards Based Management and Recognition (SBM-R)

HSD also implements activities in support of prevention, detection and treatment of gender-based violence in the community.

Purpose of Evaluation

Objective: To conduct a (near-) final performance evaluation of the USAID/Guinea Health Service Delivery (HSD) Activity. We will work with stakeholders and partners to review HSD project performance in the first 3.75 years of implementation (Dec 2015-Sept 2019).

Aim: Understand project effectiveness against the results framework, including identification and documentation of:

- Best/good practices
- Lessons learned
- Engagement of public/private sectors
- Factors affecting post-investment sustainability of service delivery processes and outcomes

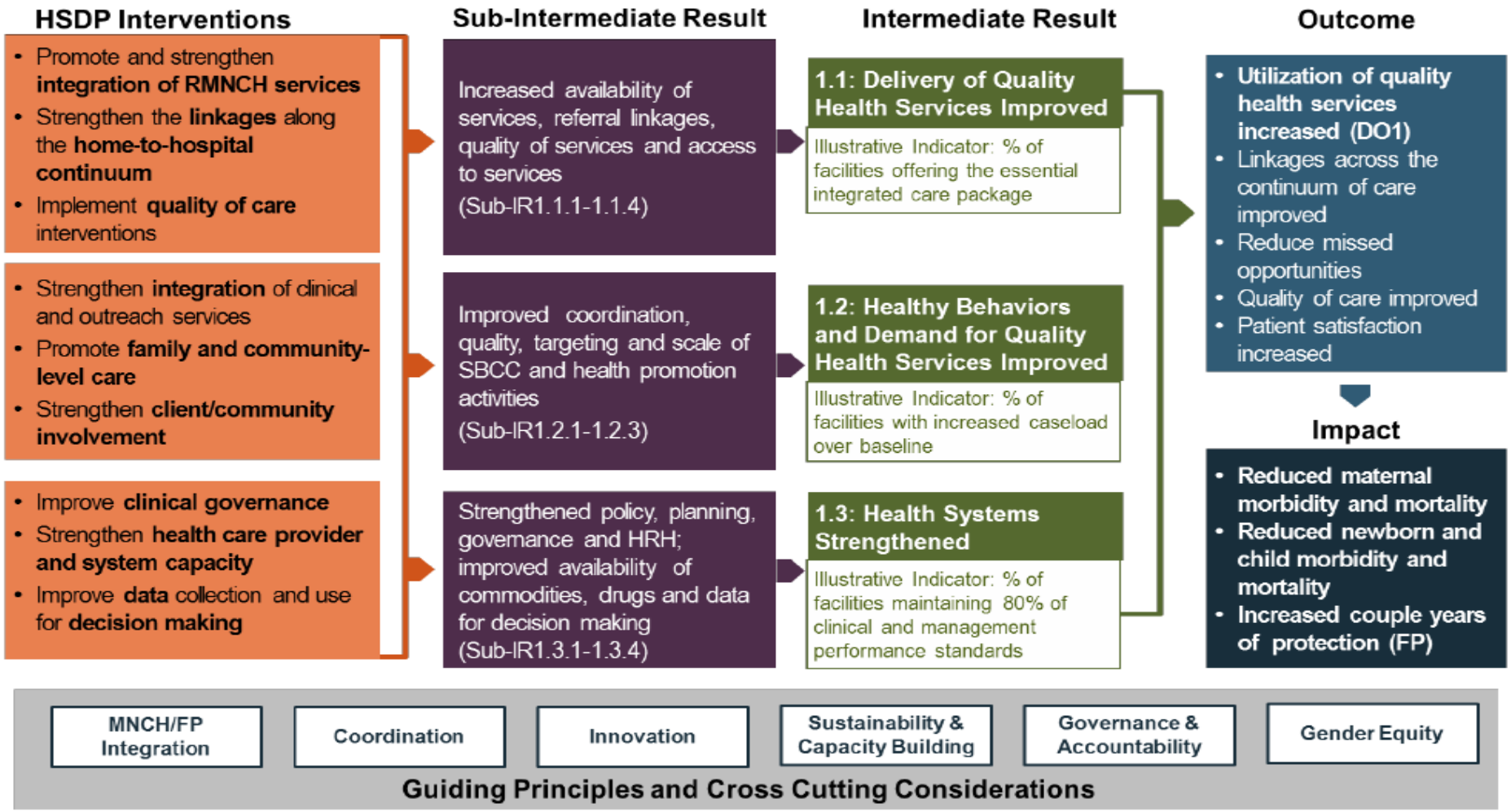
Evaluation findings will be used for three separate but closely related purposes:

Purpose 1 To enable **project implementers and managers** to understand how best to improve the implementation over the remainder of the project, including key areas of focus and potential improvement strategies;

Purpose 2 To equip **USAID and partners** with an understanding of project successes and challenges to determine implications for future USAID support to MNCH programming in Guinea and elsewhere

Purpose 3 To provide the **Guinean and US Governments** with an understanding of how the HSD experience can inform the development of their next five-year Country Development Cooperation Strategy.

HSD Results Framework



Source: JHPIEGO M&E Manual, 2016 (update 2017)

Evaluation team and roles

- **Alison El Ayadi, ScD, Team Lead -** oversee design, and lead the team towards key deliverables and activities.
- **Adriane Hilber Martin, PhD, Senior Evaluation and Implementation Advisor** - provide support to evaluation implementation, co-lead the case study development, and lend analysis expertise throughout the project.
- **Laura Buback, MPH, Technical Manager** - provide technical management and lead project coordination of field implementation, data collection, and other evaluation activities.
- **Alexandre Delamou, MD, PhD, National Evaluation and Health Systems Expert** - contribute contextual expertise, oversee data collection, and participate in analysis and interpretation.
- **Samantha Ski, DrPH, Evaluation Specialist** - oversee process management and contribute to analysis.
- **Maferinyah National Center for Training and Research in Rural Health, Evaluation Data Collection Firm** - implement field-based data collection, including survey enumeration, focus group recruitment and facilitation, regional- and facility-level key informant interviews, and all communications, translation, transcription, data entry, logistics, and in-country travel support required for execution.

Evaluation questions

1. Quality of care	*To what extent has quality of health care service improved as a result of the HSD Activity?*
2. Community focused interventions	*To what extent did HSD contribute to improved access and use of the EICP at targeted facilities?*
3. Health systems strengthening	*To what extent has HSD strengthened the health system to deliver an EICP of RMNCH+ across the continuum of care?*
4. Fistula prevention and care	*To what extent has local technical and managerial capacity been sufficiently built to support fistula prevention and care?*
5. Gender-based violence	*How well have limited financial resources been strategically directed to address gender-based violence issues under the HSD project interventions?*
6. Future perspectives	*How well did HSD complement and leverage efforts of other USAID and development partner activities to advance RMNCH+ in Guinea?*

Mixed-methods data collection

Qualitative: learning from key stakeholders

In-depth Interviews

- Ministry staff
- Hospital department heads
- Stakeholders
- Decision makers
- Key Partners/managers
- School directors

Mixed Methods Surveys

- Providers

Focus Groups

- Non facility-based community members
- Fistula and GBV
- Community mobilization groups (COSAH, etc.)

Quantitative: data review and validation

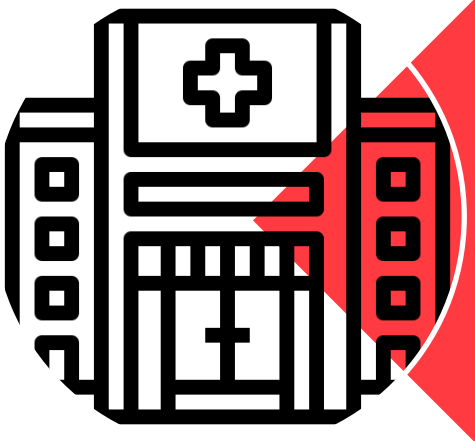
Document Review

Validation of Program Data

Facility Checklist and Observation

Individual health data and facility based data

Purposive sampling strategy



Ministry of Health Hospitals (n=10)

SBM-R performance (5 high 5 low)

3 in highly populous prefectures, 2 in less populous prefectures

Variability in entry into SBM-R program

Fistula repair services (n=3)

Health centers (n=26)

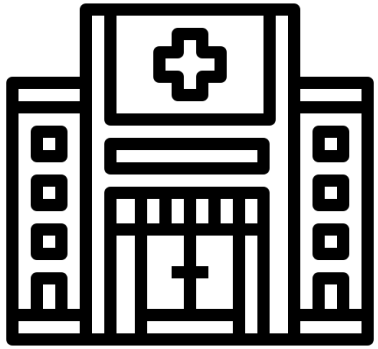
Regional representation

SBM-R and DHIS2 performance, length of time in SBM-R (as relevant) location (urban and rural), and service volume.

Range of intervention intensity

- Infrastructure improvements and receipt of equipment
- Active community components

Data Collection: Hospitals (n=10)



Facility checklist and observation (abbreviated)

Facility Manager Key Informant Interview

Provider Key Informant Interview

- Hospital Staff key informant interviews among senior-level staff responsible for overseeing RMNCH+ service delivery
- Individuals leading RMNCH+ services (antenatal care, labor and delivery, family planning, neonatal care, etc.)

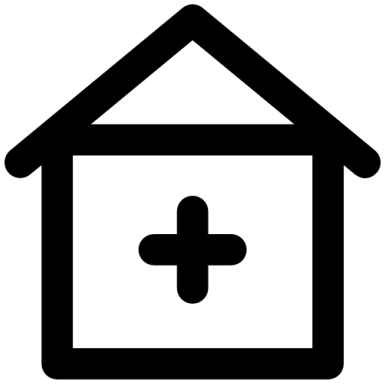
Provider surveys

- 5 per hospital (RMNCH+ providers)

Fistula care assessment

- Focus group discussions or interviews with fistula clients
- Fistula care administrators and providers were purposively selected for participation in provider KIIs and surveys where services are available.

Data Collection: Health Centers (n=26)



Facility checklist and observation (abbreviated)

Facility Manager Key Informant Interview

- Facilities offering fistula repair services will purposively include collection from fistula care managers, if different.

Provider surveys (2-3 per facility, total 60)

- RMNCH+ clinical staff, experience with new protocols and SBM-R if relevant
- Largely quantitative, some open-ended questions

Assessment of Community-based services (FGDs or group interviews)

- CHW and/or Community Mobilization Team and/or RECO surveys or FGDs
- *Note: CHWs will surveyed distinctly from the Community Mobilization Team and COSAH given their role in service provision and referral, and in some areas, their linkage with hair salons for family planning services.*
- 10 total

Client/Community Members focus group discussions (per region)

- 2 FGDs among women who gave birth in last year (1 young, 1 older)
- 1 FGD among male community members with WRA in family
- 1 FGD with COSAH
- 2 FGD (or IDI) among GBV groups

Client data review (10 per facility)

- Indicator review across registries, labor and delivery records, and health cards
- Peripartum continuum of care

Case-study: Realist evaluation of the SBM-R model

Research Questions 1 & 3: Quality and health systems strengthening

- Is the SBM-R model (+ other QI elements) leading to sustainable quality improvements in service delivery? How?
- Are the QI elements (+ community outreach elements) leading to increased uptake of specific services?

Target

- 6 facilities (4 hospitals, 2 health centers), variability in performance

Data Sources

- IDIs*, FGDs*, evaluation of monitoring and service data, and document review.
  **additional probes for SBM-R case study.*

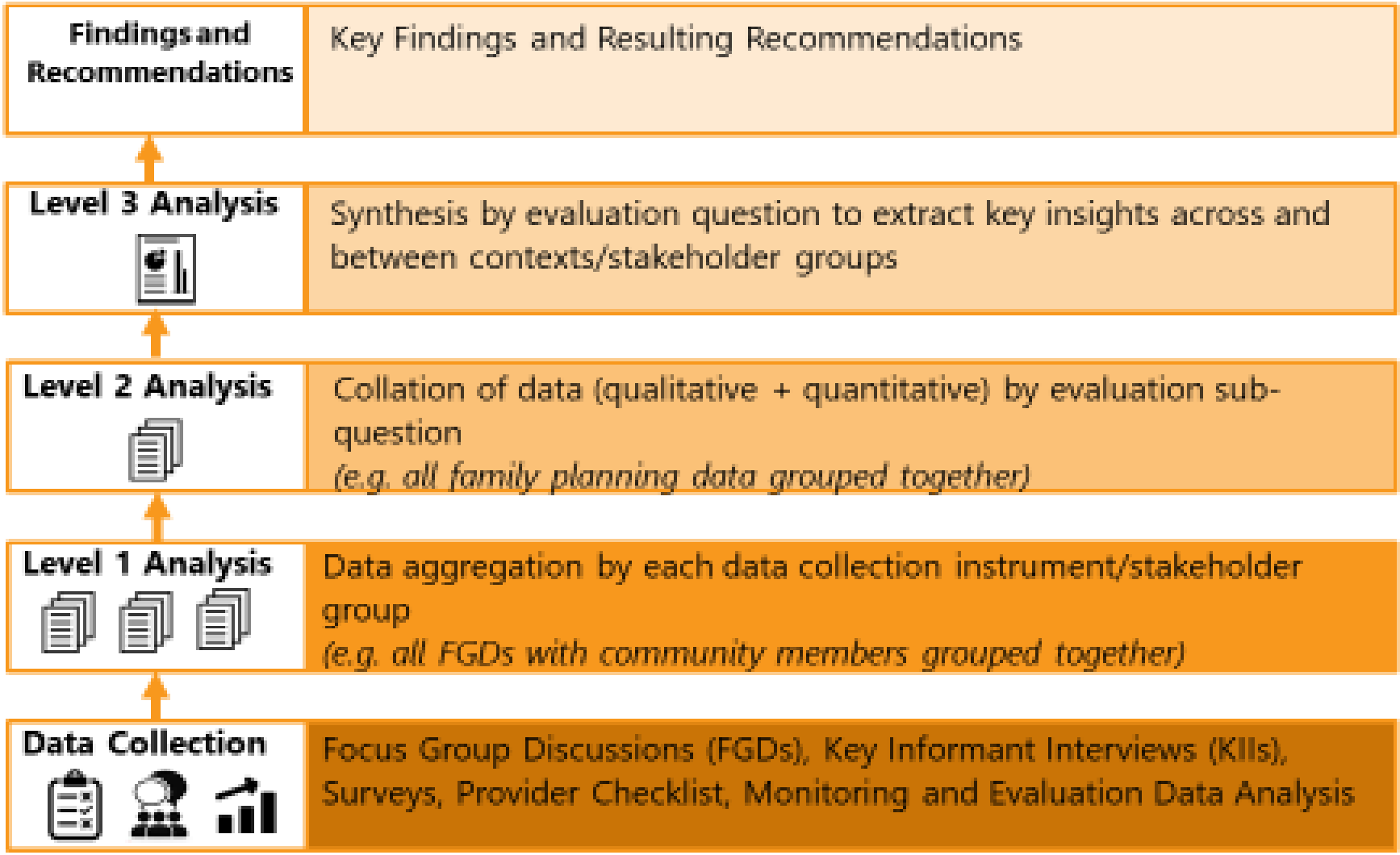
Analysis

- *Realist programme theory specifies what* mechanisms will generate the outcomes and what features of the context will affect whether or not those mechanisms operate. The context-mechanism-outcome configuration is used as the main structure for realist analysis.

Result

- A set of context – mechanism – outcome statements: "In this *context*, that particular *mechanism* fired for these actors, generating those *outcomes*" … to explain why the intervention is working in some contexts (and possibly not in others)

Analysis Procedure



Primary Data Collection: November-December 2019

	Boké	Conakry	Faranah	Kankan	Kindia	Labé	Mamou	National	Total
Qualitative									
Provider KII	7	3	16	11	12	8	8		65
Facility Manager KII	9	5	0	4	7	3	3		31
CHW/RECO KII	2	2	4	3	3	4	4		22
COSAH KII/FGD	1	1	2	1	2	1	1		9
FGD Women	1	1	2	2	2	2	2		12
FGD Men	1	0	2	1	2	1	1		8
KII Fistula Survivors	2	0	3	0	0	3	0		8
KII / FGD GBV Group	1	1	0	0	0	1	0		3
KII Decision Makers/partners	3	3	3	3	3	3	3	12	33
KII Professional School Managers	0	2	0	0	2	1	0		5
Subtotal	27	18	32	25	33	27	22	12	196
Quantitative									
Facility Checklist	6	5	3	9	6	3	3		35
Provider Survey	20	19	10	23	12	10	10		104
Data Validation	8	13	16	12	13	0	8		70
Subtotal	34	37	29	35	31	13	21		209

Limitations to the evaluation

Time period	•Rapid turn around of findings to inform strategy design •Delays due to IRB review, political demonstrations, secondary and program data requests
Data quality	•Secondary data sources incorporated •Independent assessment of health worker capacity and performance not possible
Bias	•Biases inherent to data types employed in the study (e.g., position tenure, institutional memory and individual recall, personnel transition, etc.) •Potential for desirability bias
Generalizability	•Biases inherent to data types employed in the study (e.g., position tenure, institutional memory and individual recall, personnel transition, etc.) •Potential for desirability bias
Focus	•Evaluation oriented to larger comprehensive focus thus some components smaller in scope or shorter in duration are not discussed within the evaluation •Overlapping interventions and partners in health and development sector

Findings

Question 1 - Quality of care: To what extent has quality of health care services improved as a result of the HSD activity?

- Contributed to developing a common national definition of an integrated RMNCH+ care package conforming to international norms.
- Achieved substantial progress in strengthening the system and local actors to provide integrated services

  "The project has supported health services in various areas covering the rehabilitation and equipment of the structures, the supply of drugs and inputs, staff training, formative supervision, improvement of data collection and analysis. The project has rehabilitated and equipped the operating theatre; it has provided us with equipment (respirator, delivery kits, operating tables for maternity and surgery, delivery couches, hospital beds, vacuum cleaners); it has trained health workers in EMONC, FP, partogram, and improved the quality of caesarean sections". (KII Provider, Kindia)
- Certain services cannot be considered successfully 'integrated' - Not all essential components were consistently available, and opportunities for further improvement were evident
- Challenges were faced in ensuring consistent quality of health services delivered – environment, commodity availability (stock outs), etc.
- SBM-R is an important QI approach that was an important driver of improvements in care quality and which has the potential to maintain facility and community level commitment to quality services; however, more structure and leadership is needed by MOH for sustainability.

Question 2 - Community focused interventions: To what extent did HSD contribute to improved access and use of the essential integrated care package of health services at targeted facilities?

- Utilization and access has increased throughout the continuum of care, however some services are still more utilized than others – e.g., facility delivery and postpartum care had slower uptake, vertical vs. horizontal approach

  "They come more to the facilities for MCH services, family planninng, deliveries, caesarean sections through the educational sensitization of CHWs, maternal deaths are reduced. For example, 14 maternal deaths in the first half of 2019 compared to only six in the second half of 2019." (Provider, Faranah)

- Community Health Policy and CHW motivation posed challenges

  "To improve the quality of community health services it would be necessary to equip the health post, supply medicines and increase the number of staff." (Men, Kindia)

- Referral system interventions focused on increasing availability of communication; remains dysfunctional

  - *"The community health workers do not make referrals nor do they direct women to health facilities; It is our neighbors who send us to the hospital"." (FGD Women, Conakry)*

Question 2 - Community focused interventions – *continued*

- SBCC approach (CHWs, health talks, COSAH) had some small scale impact at community level
  - *"Family planning before was a taboo subject that they didn't dare to utter. I myself have attended several regional meetings where the leaders of the Islamic league have participated. Since then, awareness has increased and now you can talk about family planning" (FGD men, Labe)*
- Disparities in RMNCH+ service utilization existed due to financial barriers to care
  - *"If you go to the hospital without money, you die. You can spend up to 100,000fg on counseling and medication…we wanted it to be free..." (FGD Women, Conakry)*
- Community interventions did not have a strong equity focus and barriers remain for women, youth, and the most vulnerable
  - Transportation/roads; Lack of information/rumors; Stigma/Shame; Male/partner permission

Question 3 - Health systems strengthening: To what extent has HSD strengthened the health system to deliver an integrated package of RMNCH+ health care services across the continuum of care ?

- HSD has **strengthened the *potential* of national and local governance** for HS improvement through training, managerial guidance, QI processes, follow-up and support
- **Provision of equipment and infrastructure improvements** in some facilities contributed to quality of integrated health services, building community trust and supporting utilization of services.

  "HSD has improved the availability of equipment, and drugs through significant contributions that facilitate access to care, access to drugs for comprehensive management of fistula patients, an example being the management of fistula. These various aids have helped to attract patients to the center and increase revenues. (FGD COSAH, Labé)

- **Inadequate maintenance of equipment or infrastructure by MoH, and a** high level of impunity, control and accountability exists at facility, and MoH managerial levels undermines efforts to sustain improvements in the health sector.
- **Increased availability of drugs and commodities at facilities, but recurring and prolonged stock outs** of RMNCH+ products in some facilities limited care provision.

Question 3 - Health systems strengthening - *continued*

- **HSD improved data collection, quality, reporting and use of data for decision-making** at the facility, district and regional leading to service delivery improvements that was also recognized by COSAH's and clients.

  "The analysis of the data and the recommendations made led to a commitment that enabled the structure to increase its performance in the use of the partogram from 19% to 77% and then 94% thanks to HSD". (KII Facility manager, Labé)

- **Capacity development, curriculum and tools through in-service training at selected nursing and midwifery schools was a successful and important component of the project**

- **Post investment sustainability is at risk due to low level of MOH leadership, ownership and accountability** – post-investment sustainability is considered the responsibility of the government, QI efforts require adequate monitoring and supervision across all levels of health governance

  "Change starts from the top! [Le poisson pourri par la tête.] (KII Facility Manager, Boke)

- **Many of the sub-components of the HSD activity are currently not well positioned to be sustained without external support**

Question 4 - Fistula prevention and care: To what extent has local technical and managerial capacity been sufficiently built to support fistula prevention and care in Guinea?

- Contributed to building fistula surgical capacity and coverage in Guinea through training of providers, demand creation and direct support to surgical repair in existing and new repair hospitals – including community-level fistula screening to refer women to care
  "There are qualified surgeons for the management of fistula that can continue [the work] after the end of the HSD project, provided that there is a third-party payer since the management is costly, not less than 300 to 600 US dollars per repair". (KII Provider)

- HSD has effectively supported clinic and community-based prevention activities to prevent the occurrence of fistula in Guinea – though common delays in accessing timely care persist
  "We don't have an ambulance, our women who are referred suffer a lot especially if it is late in the night" (KII CHWs).

- Reintegration activities provided under HSD activity were largely effective in terms of supporting women to reenter their communities – though programming was inconsistently implemented, and further follow-up among women post-repair is needed
  "We help women to reintegrate into their communities after undergoing treatment by raising awareness among the population" (FGD Men)

- Sustainability of fistula care services is a large concern given the cost and the significant backlog of women still awaiting fistula surgery

Question 5 - Gender Based Violence: How well have the limited financial resources been strategically directed to address GBV issues under the HSD project interventions? What could have been done differently to enhance achievement of results?

- The limited financial resources devoted to GBV under the HSD activity have been reasonably effective in strengthening the health system's capacity to address gender-based violence, particularly in the regions targeted, and in incorporating GBV-specific policies in reproductive health guidelines

- Continued social and behavior change efforts are needed to enhance prevention, incorporating high level support, mobilizing champions to speak out on GBV, including FGM.

  "Everybody shows off and that's what it is all about. In order to avoid being raped, you have to wear the right clothes, that's what is good for women. to dress properly, how to give priority to wearing the right clothes, because if you meet someone you're not properly dressed if they want you, they'll have you, so that's what we have to let them know, is to dress properly to protect ourselves." (FGD Women)

- The small amount of money available for GBV is under-leveraging other GBV investment and is not well-connected to a broader, nationally owned strategy.

  "Certainly there are results but without good coordination we cannot capitalize on the results" (KII-National)

Question 6 - Future perspectives: How well did HSD complement and leverage efforts of other USAID and development partner activities to advance RMNCH results in Guinea?

- Activities were designed to build on prior USAID-supported activities and complement concurrent USAID/partner-supported programming.
- Synergies across USAID activities were particularly effective during EVD epidemic – increased communication and collaboration through regular meetings and shared tasks across partners
- Efforts to design activities to be complimentary was recognized; rigid boundaries between activities over the project life created gaps.
- Some cross-partner activities were felt to be well-leveraged by USAID, and complementarity to other stakeholder projects was also noted as a strength of the USAID approach.
- USAID supported projects were felt to be covering many issues, but support of other donors is still needed.
- Post-investment sustainability remains a concern, with lack of sustainability of inputs by the MOH at all levels - financial, managerial, leadership

Recommendations

RECOMMENDATIONS: 1. AVAILABILITY OF INTEGRATED CARE AND QUALITY OF CARE

1.1. Target engagement of clients throughout the continuum of care, with a particular focus on improved engagement in the postpartum period, and institutionalize functional referral systems to strengthen quality of care improvements.

1.2. Augment or continue support for integrated critical services for the most vulnerable, including adolescents and youth, women in need of fistula surgery, and survivors of gender-based violence.

RECOMMENDATIONS: 2. THE LAST MILE: REACHING THE MOST VULNERABLE AND COMMUNITY LEVEL

2.1. Support the Government of Guinea to implement the Community Health Policy and integrate community health services.

2.2. Strengthen community engagement through support for the Community Action Cycle, community groups, and local health posts

2.3. Social accountability for removing financial, gender and cultural barriers for the most vulnerable including through addressing service fees for critical services and supporting community health mutuals.

RECOMMENDATIONS: 3. HEALTH SYSTEMS STRENGTHENING: BUILDING ON SUCCESSES

Governance and Quality Improvement Processes

3.1. Require accountability, leadership and ownership from implementing partners for sustainability through results-based measures for accountability

Sustainability

3.2. Align SBM-R with existing quality improvement measures of the Government of Guinea and Ministry of Health and advocate for an institutionalized quality improvement approach system-wide

3.3. Continue support to the DHIS2 health information system to achieve full implementation to facilitate evidence-based decision making

3.4. Scale up support for pre-service midwifery and nursing education and skills labs as an important investment for ensuring the evidence-based, quality clinical service delivery

3.5. Strengthen facility-based management of equipment, infrastructure, and supplies, which is fundamental to the provision of quality integrated services.

RECOMMENDATIONS: 4. USAID AND PROGRAM OVERSIGHT: PROGRAMMING FOR SUSTAINABILITY

Leveraging, Adaptation, and Problem Solving

4.1. USAID should leverage its health sector investments for improved collaboration, communication and impact between its projects/activities and others in the health development field

4.2. Flexibility in project design, implementation and outcome measures are needed to adapt to changing context and needs

Design for Sustainability

4.3. Design projects collaboratively to increase ownership and devolve responsibility to government partners

4.4. Consider demonstrating the full effectiveness of investment activities by prioritizing depth of investment

Discussion

Supplemental Slides

Field management (Maferinyah)

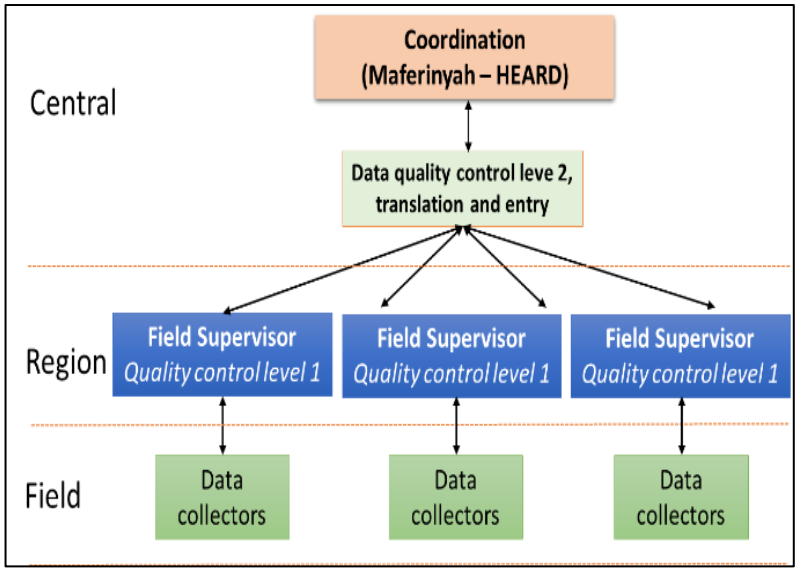
Coordination: Prof. Alexandre Delamou with support from Dr. Bienvenu Camara.

7 experienced field teams:

- 1 supervisor: manage quantitative data collection
- 2 qualitative data collectors
- 1 driver

Facilitation of data collection and transmission:

- Laptop and android phone
- Digital voice recorders
- Internet keys



Anticipated length of field work per team/region:

- 2 days travel
- 1 day introductions/administrative documents
- 13 days of data collection

HSD Indicators

Cross-cutting indicators:
H1. Number of people trained in FP/RH with USG funds
H2. Number of people trained in maternal/newborn health through USG-supported programs
H3. Number of people trained with USG assistance to advance outcomes consistent with gender equality or female empowerment
H4. Number of health workers trained in new IPC protocols

IR 1.1 Delivery of quality health services increased
H5. Percentage of health facilities achieving/compliant with 80% of performance standards
H6. Number of health facilities offering the complete package of integrated essential RMNCH care
H7. Percent of USG-assisted service delivery sites providing family planning counseling and/or services.

IR 1.2. Healthy Behaviors and Demand for Quality Health Care Services Improved
F18. Couple years of protection
F19. Percentage increase in facility attendance per year in the USG supported area
H20. Number of organizations collaborating with USAID to design, implement, monitor and evaluate health communication programs
H21. # of health messages disseminated through any communication channel (radio, TV, mobile, small/large group discussions).

IR 1.3. Health Systems Strengthened
H22. Percentage of faculty/preceptors who achieve 80% of clinical training performance standards
H23. Percentage of health service providers and community health workers displaying/demonstrating skills in service delivery according to national standards
H24. Average stock out rate of contraceptive commodities at service delivery points by family planning method
H25. Number of laws, policies or procedures drafted, updated or adopted to promote health equity at the local, regional, or national level.

IR 1.1.1 Integrated quality maternal, neonatal, and child health
H6. Number of health facilities offering the complete package of integrated essential RMNCH care
H7. Percent of USG-assisted service delivery sites providing family planning counseling and/or services.

IR 1.1.2. Referral linkages strengthened
H8. Number of children under 5 received by health workers upon onset of symptoms by CHW
H9. Number of children that are treated by the CHW within 24 hours
H10. Number of children that are referred to the health facilities by the CHWs

IR 1.1.3. Availability of prevention care and treatment services increased

IR 1.1.4. Access to health care improved
H11. Number of pregnant women who had 4 prenatal visits (CPN) including 1 at the last month
H12. Number of women giving birth who received uterotonics in the third stage of labor (or immediately after birth) through USG-supported programs
H13. Number of newborns not breathing at birth who were resuscitated in USG-supported programs
H14. Number of children <5 years with symptoms of diarrhea receiving care management
H15. Number of fistula surgeries performed
H16. Number of USG-assisted CHWs providing FP information, referrals, and/or services during the year
H17. Number of people reached by a USG funded intervention providing GBV services (health, legal, psychosocial counseling, shelters, hotlines, etc.)

Why Realist Evaluation?

"What works, for whom, in what respects, to what extent, in what contexts, and how?"

- Realist evaluators aim to identify the **underlying generative mechanisms** that explain '***how***' the outcomes were caused and the influence of context.
- Considers that an intervention works (or not) because actors make particular decisions in response to the intervention (or not). The 'reasoning' of the actors in response to the resources or opportunities provided by the intervention is what causes the outcomes (i.e. 'generative mechanism').
- Context matters: firstly, it influences 'reasoning' and, secondly, generative mechanisms can only work if the circumstances are right.
- Realist evaluation is method-neutral (i.e., it does not impose the use of particular methods).
- Indicated for complex, health systems interventions as it can indicate the conditions in which the intervention works (or not) and how they do so.
- Realistic specification allows decision makers to assess whether interventions that proved successful in one setting may be so in another setting, and assists programme planners in adapting interventions to suit specific contexts.