Evaluation

Evaluation of USAID's Tubiteho project in Burundi

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Evaluation

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Abstract

This evaluation assesses USAID's Tubiteho project in Burundi, implemented by Pathfinder and its partners from 2019 to 2024. The evaluation aims to determine the extent to which Tubiteho achieved its objectives across three intermediate results: increasing access to quality essential health services, promoting the adoption of positive health behaviors, and strengthening health systems. Key evaluation questions include factors influencing the project's success, integration of local perspectives, and sustainability plans.

A mixed-methods approach was employed, involving in-depth interviews, key informant interviews, and focus group discussions across selected provinces. Data were gathered from various informants, including government officials, USAID staff, implementing partners, health providers, community health workers, and community members.

Key findings indicate that while Tubiteho's strategies and integration efforts were largely effective, there were notable gaps in monitoring and evaluation and certain service areas. Further, persistent challenges such as cultural resistance, resource shortages, and economic constraints continue to affect the project's overall impact. Continuous adaptation, enhanced data collection, and targeted interventions are needed to address these challenges and improve future project outcomes.

Recommendations emphasize the need for sustained capacity strengthening, resource allocation, and infrastructure development to ensure long-term impact and sustainability. Enhanced data collection and monitoring practices are also crucial for ongoing performance assessment. The evaluation concludes that Tubiteho made progress in its goals, offering valuable lessons for future health interventions in similar contexts.

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Cover

Photo of the Tubiteho team by USAID Burundi 2023.

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Abbreviations

ANC: antenatal care

BEmONC: basic emergency obstetric and neonatal care

BPS: Bureau Provincial de Santé (Provincial Health Office)

CDS: centre de santé (health center)

CEPBU: Communauté des Eglises de Pentecôte du Burundi (Pentecostal Church)

CERPED: Centre d'Etudes et de Recherche en Population et Développement (Center for Population and Development Studies)

CHW: community health worker

CPSD: Cadre de Partenariat pour la Santé et le Développement provincial (Partnership Framework for Health and Development)

D4I: Data for Impact

DHS: Demographic and Health Survey

EmONC: emergency obstetric and neonatal care

FGD: focus group discussion

FP: family planning

GBV: gender-based violence

IDI: in-depth interview

IHPB: Integrated Health Project in Burundi

IP: implementing partner

IPTp: intermittent preventive treatment in pregnancy

IR: intermediate result

JICA: Japan International Cooperation Agency

KII: key informant interview

MCH: maternal and child health

MOH: Ministry of Health

M&E: monitoring and evaluation

PBF: performance-based financing

PMC: Population Media Center

PNSR: Programme Nationale de Santé de la Reproduction (National Reproductive Health Program)

PNILP: Programme Nationale Intégré de Lutte Contre le Paludisme (National Integrated Malaria Control Program)

PSI: Population Services International

SGBV: sexual and gender-based violence

TPS: technicien de promotion de la santé (health promotion technician)

UNICEF: United Nations Children's Fund

USAID: United States Agency for International Development

Executive Summary

Purpose and background

This report presents the findings of a process and performance evaluation of USAID's Tubiteho project in Burundi, implemented by Pathfinder and its partners from 2019 to 2024. The project aimed to strengthen Burundi's health system, with goals to increase access to quality essential health services, promote positive health behaviors, and enhance health system capacity. This evaluation was conducted to assess the extent to which these objectives were met, identify facilitating and inhibiting factors, understand how local perspectives were integrated, and provide recommendations for future programming.

Evaluation questions

The evaluation focused on the following key questions:

Performance evaluation

1. To what extent did Tubiteho achieve its objectives across three intermediate results: increased access to health services, adoption of positive health behaviors, and strengthened health systems?
2. What factors facilitated or inhibited Tubiteho's success?
3. How were local perspectives integrated into Tubiteho's planning and implementation?
4. What are the plans and prognosis for sustainability after the project ends?

Process evaluation

5. What lessons learned can inform the remainder of the project and future designs?
6. Were the objectives, activities, and indicators well defined and aligned with USAID/Burundi and MOH strategies?
7. Has Tubiteho collected adequate monitoring and evaluation data to capture performance?
8. How has project integration affected objectives in key areas such as family planning (FP), maternal and child health (MCH), malaria, nutrition, and gender-based violence (GBV)?

Methods

The evaluation employed a mixed-methods approach, including in-depth interviews, key informant interviews, and focus group discussions across selected provinces. Data were collected from a variety of informants, including government officials, USAID implementing partners, health providers, community health workers, and community members. The evaluation covered both the northern and southern regions of Burundi, focusing on districts in Kirundo and Bururi provinces.

Findings

Performance evaluation

The performance evaluation of the Tubiteho project assessed the extent to which the project achieved its objectives in increasing access to quality essential health services, promoting the adoption of positive health behaviors, and strengthening health systems in Burundi.

Family planning: Tubiteho provided training to health providers and community health workers on contraceptive methods, which improved access to family planning services. However, cultural and religious resistance, particularly among men, remains a significant barrier to wider adoption.

Maternal and child health: The project enhanced maternal and child health services through capacity strengthening for providers, distribution of medical equipment, and promoting early prenatal consultations. These efforts contributed to reductions in maternal and infant deaths, though challenges such as drug stockouts and poverty persist, limiting full access to care.

Malaria: Tubiteho improved malaria management by training community health workers and ensuring the availability of testing and treatment kits. The project's responsive approach, including the use of mobile clinics during epidemics, helped reduce malaria incidence in targeted areas.

Gender-based violence: The project strengthened gender-based violence services by training health providers and community volunteers to manage cases and raise awareness. While these efforts improved service accessibility, economic barriers and social stigma still prevent some survivors from seeking care.

Nutrition: Tubiteho focused on raising awareness about good nutrition practices and screening for malnutrition. However, the project's impact was limited due to the absence of therapeutic interventions for malnourished children and the widespread poverty that hindered households' ability to follow nutritional advice.

Adoption of positive health behaviors: The Tubiteho project promoted the adoption of positive health behaviors through various awareness-raising strategies, including mass media campaigns, group education, and community engagement. These efforts increased the demand for health services, as evidenced by higher utilization rates, particularly for maternal and child health services. The project also played a key role in shifting gender norms, encouraging collaborative decision making in health, and reducing gender-based violence by raising awareness and involving men in advocacy efforts. Despite these successes, challenges such as cultural resistance and economic barriers continue to affect the full adoption of positive health behaviors.

Strengthened health systems: The Tubiteho project strengthened Burundi's health systems by developing and disseminating health protocols and guidelines, particularly for voluntary medical male circumcision and modern contraception methods, ensuring standardized practices across facilities. The project also improved client management systems within health facilities, leading to better patient flow, reduced wait times, and more effective care, especially for sensitive cases like gender-based violence. Quality improvement teams were established to oversee and enhance service delivery, reducing the need for patient referrals and enabling facilities to manage more complex cases on-site.

Inhibiting and limiting factors: The Tubiteho project's success was facilitated by strong community engagement, effective training of health providers and community health workers, and the integration of services across various health domains. These factors enhanced trust in the health system and improved service delivery. However, the project faced significant limiting factors, including cultural and religious resistance to certain health interventions, particularly family planning, high staff turnover, resource constraints such as drug stockouts, and economic barriers that hindered access to services. These challenges limited the project's overall impact and highlighted areas where further support is needed to achieve sustainable health outcomes.

Localization: The Tubiteho project made efforts to localize its interventions by actively engaging individuals in local communities, health workers, and leaders in supported areas in planning and implementation. This approach ensured that the project was responsive to the specific needs and cultural contexts of the communities it served. Local perspectives were integrated into service delivery, particularly through the involvement of community health workers and local organizations, which helped build trust and enhance the effectiveness of health interventions. However, the extent of localization varied, with some areas showing stronger integration of local input than others.

Sustainability: The sustainability of the Tubiteho project's outcomes remains a mixed picture. While the project made strides in strengthening local capacity through training and the development of protocols, challenges persist in ensuring long-term impact. Sustainability plans focused on continued capacity strengthening, resource allocation, and the integration of services within the local health system. However, the reliance on external resources and the ongoing challenges of high staff turnover and resource limitations raise concerns about the country's ability to maintain project achievements after its conclusion. The need for robust local ownership and consistent support remains critical for sustaining the project's benefits.

Process evaluation

The process evaluation examined the effectiveness of the Tubiteho project's implementation strategies; the adequacy of its objectives, activities, and indicators; and how these factors contributed to the achievement of project goals.

Lessons for project management: The project adapted its strategies to local contexts by engaging with community health workers, facility-based health workers, and local leaders. This localized approach facilitated better integration of services and enhanced community trust in health interventions. However, the project faced challenges in continuously training new staff due to high turnover rates, highlighting the need for sustained capacity-strengthening efforts.

Adequacy of objectives, activities, and indicators: Tubiteho's objectives were generally well aligned with USAID/Burundi and the Ministry of Health strategies. However, the project encountered difficulties in fully capturing its performance through monitoring and evaluation due to gaps in routine data collection and reporting. This was particularly evident in the nutrition domain, where the lack of therapeutic interventions for malnutrition was a significant shortcoming.

Monitoring and evaluation data collection: The project's monitoring and evaluation framework faced limitations in tracking comprehensive performance data, particularly at the community level. While efforts

were made to collect data on routine indicators, inconsistencies in data quality and reporting hindered a complete assessment of the project's impact. Strengthening monitoring and evaluation systems is crucial to better capture project outcomes and inform future program decisions.

Impact of project integration: Tubiteho's integration of services was largely successful, leading to improved service delivery and patient outcomes. For instance, the integration of family planning with maternal health services facilitated better access to contraceptives. However, some challenges persisted, such as resistance from faith-based health facilities regarding modern contraceptives and the limited reach of nutrition interventions.

The process evaluation revealed that while Tubiteho's strategies and integration efforts were largely effective, there were notable gaps in monitoring and evaluation and certain service areas, particularly nutrition. Continuous adaptation, enhanced data collection, and targeted interventions are needed to address these challenges and improve future project outcomes.

Recommendations

Future health projects in Burundi should focus on several key areas aligned with the World Health Organization's six building blocks of health systems:

1) For **leadership and governance**, establishing a national behavior change communication policy and developing tools for integrating services are recommended. Strengthening community-based structures for improved local health governance is also crucial.
2) In **service delivery**, future projects should build on Tubiteho's integration efforts, especially in combining sexual and gender-based violence and health services. Improving access through the construction and rehabilitation of health centers, establishing national quality standards, and promoting public-private partnerships are also recommended.
3) In terms of **financing**, supporting health insurance schemes and exploring performance-based financing to enhance workforce satisfaction and productivity is essential.
4) For the **workforce**, the focus should be on improving remuneration and developing community health programs, especially for rural and marginalized populations.
5) **Medical products** should be consistently available, requiring a robust system for the continuous supply of equipment and drugs.
6) In **information systems**, improving data quality, digitizing medical records, and enhancing epidemiological surveillance are key priorities. Lastly, behavior change strategies should involve tailored communication approaches that engage religious leaders and emphasize male participation in family planning and gender-based violence awareness.

To promote sustainability, future projects should establish a joint planning system led by the Ministry of Health, involving USAID, implementing partners, and other health actors to harmonize priorities and approaches. A phased transfer of responsibilities from implementing partners to local districts should be planned from the outset to ensure long-term sustainability.

Commitment from the Ministry of Health to mobilize its staff at all levels is crucial for the success of these efforts. Lessons from Tubiteho highlight the importance of early engagement with the Ministry of Health and the necessity of strong partnerships between USAID and implementing partners. To avoid delays, it is recommended that the workplan approval process be streamlined.

Future projects should also allocate sufficient human and financial resources, particularly at the provincial and district levels, to support large-scale health initiatives. The consortium model used in Tubiteho was valued and should be continued, but with sufficient time allocated for capacity strengthening of local partners.

Additionally, a midpoint evaluation should be conducted to allow for course corrections, supported by data quality assessments to ensure reliable information for decision making.

Conclusions

The Tubiteho project made significant progress toward its objectives, particularly in improving access to essential health services and strengthening health systems. However, challenges remain, particularly in overcoming cultural barriers, ensuring resource availability, and addressing economic constraints. The lessons learned from Tubiteho offer valuable insights for future health interventions in similar contexts.

Evaluation Purpose and Questions

The evaluation of the Burundi Tubiteho project consists of two parts. The first is a performance evaluation aiming to: (a) assess to what extent the Tubiteho project achieved its objectives for three intermediate results (IRs) and nine sub-results; (b) understand the factors that inhibited or facilitated Tubiteho's success in achieving its objectives; (c) assess how local perspectives have been integrated into Tubiteho's planning and implementation, and how they view the project; and (d) identify the Tubiteho project's plans for sustainability and prognosis after the project ends.

The second part is a process evaluation to identify: (a) what lessons learned can inform the Tubiteho project's management for the remainder of the project life and future potential follow-on designs; (b) if the objectives, activities, and indicators used for Tubiteho implementation were well defined (compared with USAID/Burundi and MOH strategies); (c) if Tubiteho collected adequate monitoring and evaluation data on routine performance indicators to capture project performance; and (d) how the project integration has improved and/or hindered the achievement of objectives in family planning (FP), maternal and child health (MCH), malaria, nutrition, and gender-based violence (GBV).

The evaluation will assist the United States Agency for International Development (USAID) by assessing the degree to which the project achieved its goals, as well as the enabling and limiting factors, in order to inform future USAID/Burundi programming decisions around Family PlanningFP, Maternal and Child Health, Malaria, Nutrition, and Gender-Based Violence. This work serves as a process and performance evaluation of the Tubiteho project to determine the extent to which the Tubiteho project has met its overarching objectives of: (1) increasing access to quality essential health services; (2) increasing adoption of positive health behaviors; (3) strengthening health systems for health service delivery; and (4) integrating local perspectives into Tubiteho's planning and implementation. This evaluation will complement any evaluation efforts already implemented as part of the Tubiteho project's Performance Management Plan (PMP).

The target audiences for the Tubiteho evaluation are Pathfinder (the project implementer), other implementing partners within the consortium (the Pentecostal Church [CEPBU], Association Dushirehamwe, Population Media Center, and Population Services International), Burundi Ministry of Health, district leadership, hospital management, health center management, health workers, community health workers, local organizations, community leaders, program beneficiaries, local communities, and USAID.

The performance evaluation research questions are:

1. To what extent did Tubiteho achieve its objectives for the three intermediate results and nine sub-results?
2. What factors inhibited or facilitated Tubiteho's success in achieving its objectives?
3. How have local perspectives been integrated into Tubiteho's planning and implementation, and how do they view the project?
4. What are the plans and prognosis for sustainability after the project ends?

The process evaluation research questions are:

5. What lessons learned can inform project management for the remainder of the project life and future potential follow-on designs?
6. Were the objectives, activities, and indicators used for Tubiteho implementation well defined (compared with USAID/Burundi and MOH strategies)?
7. Has Tubiteho collected adequate monitoring and evaluation data on routine performance indicators to capture project performance? Why or why not?
8. How has project integration improved and/or hindered the achievement of objectives in Family Planning (FP), Maternal and Child Health (MCH), Malaria, Nutrition, and Gender-Based Violence (GBV)?

Background

Burundi, a landlocked country in East Africa, remains one of the most poorly developed countries in the world, with significant challenges in the health sector affecting the lives and livelihoods of Burundians. It has a population of 13.2 million people, the majority of whom are subsistence farmers (World Bank, 2024). Countrywide, neonatal disorders, diarrheal diseases, and malaria are the top three diseases contributing the most to the country's disease burden (Institute for Health Metrics and Evaluation [IHME], 2019). Malnutrition is one of the top drivers of death and disability; 56 percent of children under the age of 5 are chronically malnourished (World Food Program USA, 2024). Of the factors contributing to mortality, the top five fall under the categories of communicable, maternal, neonatal, and nutritional diseases, with diarrheal diseases causing the most deaths amongst populations of all ages (IHME, 2019).

Burundi's health system is structured in four major cadres: the central level (Ministry of Health and its various programs), the intermediate level (provincial health bureaus, national referral hospitals, and provincial/regional hospitals), the local level (district health bureaus and hospitals), and the community level (health centers and community health workers [CHWs]) (Severe Malaria Observatory, 2024). From 1993 to 2005, the country went through a civil war that decimated the economy and health infrastructure, leaving millions without access to adequate and timely care (Philips et al., 2004). Despite the country's recovery efforts, access to health services remains limited, especially among impoverished and rural populations. There are 0.1 physicians per 1,000 population and fewer than 1 hospital bed per 1,000 population (World Bank, 2019). Hospitals are understaffed and struggling with a high staff turnover rate, access to essential medications and equipment is low due to frequent stockouts, poor infrastructure development renders existing health services inaccessible to many throughout the country, and affordability of services and ability to pay for services continue to hinder access to quality health services for impoverished and marginalized populations (Gupta et al., 2011; Habonimana et al., 2022; Nimubona, 2022).

To help address the health challenges in Burundi, USAID launched Tubiteho ("Let's Take Care of Them"), an integrated health service delivery project, in 2020. Implemented through Pathfinder, the project aimed to strengthen the country's health system through capacity strengthening (trainings and supportive supervision) for health workers and local health partners, improving the quality of and access to health services through integration and provision of essential supplies, promoting the uptake of positive behaviors around GBV and FP through community mobilization and advocacy. The USAID/Burundi Mission funded the evaluation of Tubiteho contract no. 72069519CA00001. The life of the project/activity ran from August 30, 2019 to August 29, 2024.

Tubiteho aimed to improve the health of Burundians, especially women, children, and infants. The project was implemented in 16 health districts across six provinces and covers 390 facilities. Tubiteho worked with local partners to improve and strengthen the delivery of health services in five key areas: Family Planning (FP), Maternal and Child Health (MCH), Malaria, Nutrition, and Gender-Based Violence (GBV), through the following activities:

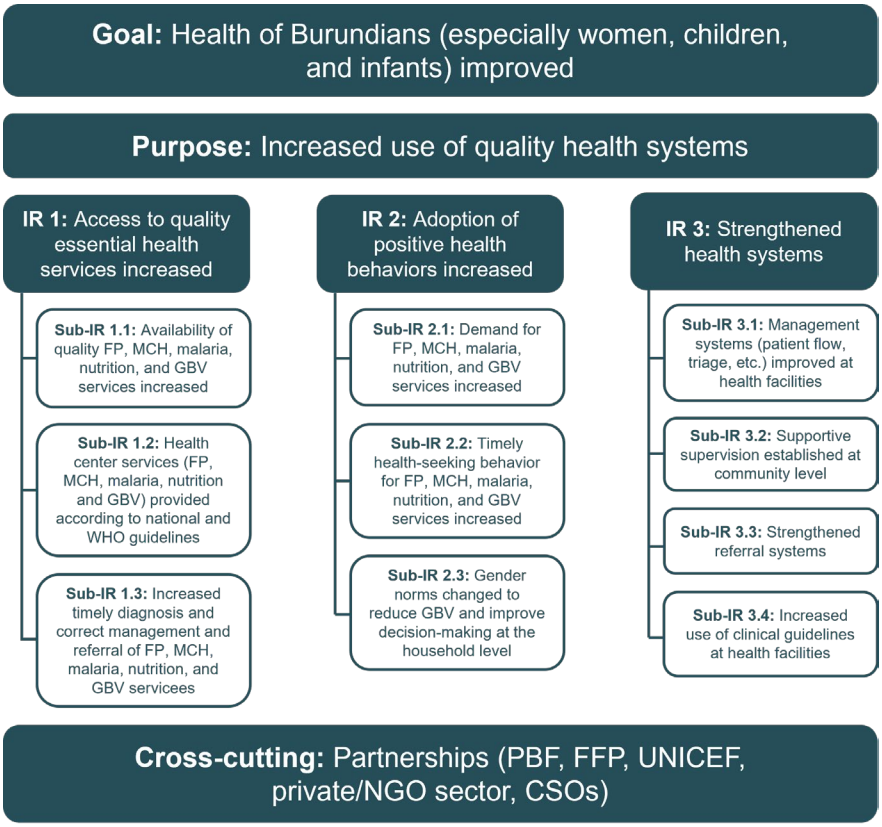
- Strengthen the capacity of local service providers (public, private, and faith-based health facilities and communities) to provide quality FP, malaria, and maternal and child health services.
- Integrate FP services into other MCH services, especially immediate post-partum FP counseling

and at HIV treatment sites, to support the needs of women living with HIV to access FP services.

- Support prevention, care, referrals, and education related to malnutrition.
- Deploy mobile clinics during periods of peak malaria incidence to hardest hit areas in the northern and southern provinces to provide malaria services, as well as to implement malaria-control activities.
- Enlist the support of community leaders and gatekeepers in community education and mobilization related to new malaria-treatment guidelines.
- Use radio programs to bolster and intensify campaigns for behavior change related to health issues addressed by Tubiteho.
- Seek to reduce GBV by conducting gender sensitization trainings with project and partner staff, enabling them to integrate what they learn into project interventions.

Tubiteho's results framework had three intermediate results that address both supply and demand factors around health services, including (1) increased access to quality essential health services, (2) increased adoption of positive health behaviors, and (3) strengthened health systems for health service delivery. The results framework is shown in Figure 1.

Figure 1. Tubiteho results framework



Methods and Limitations

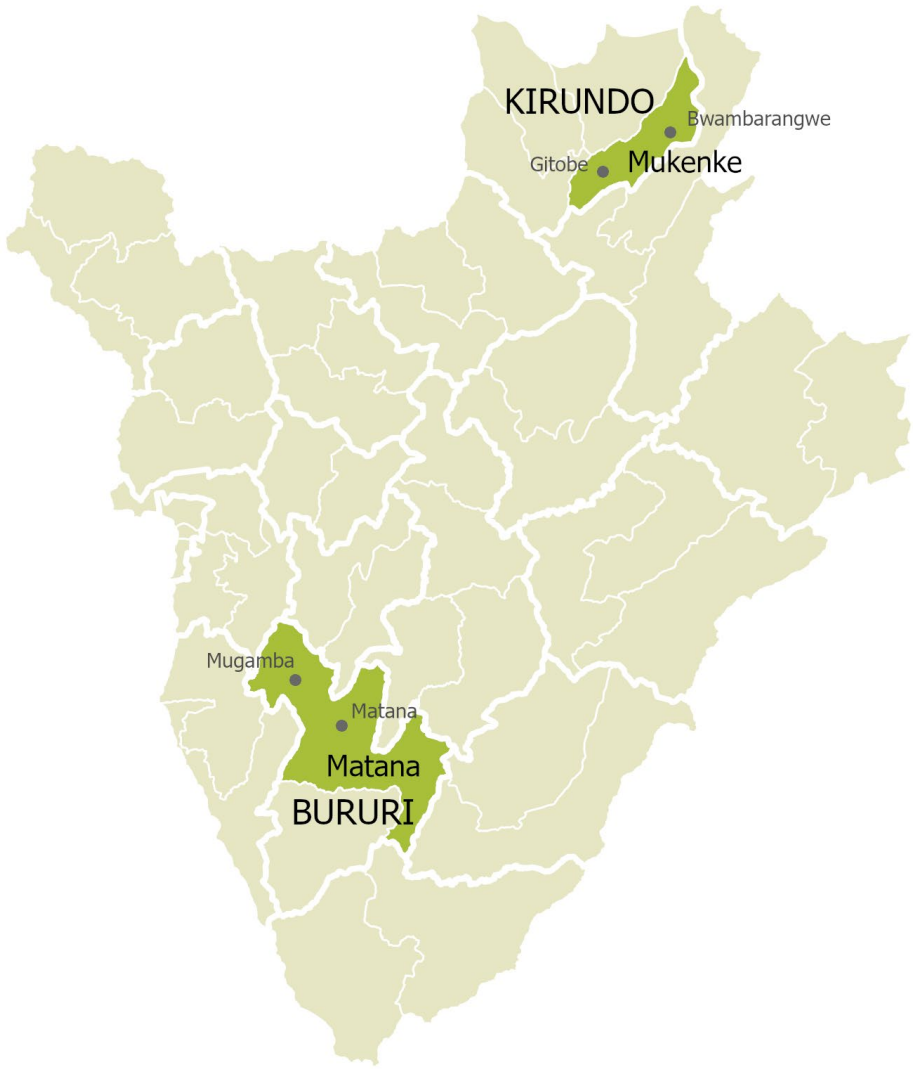
Evaluation Design

The evaluation was conducted through a qualitative approach using in-depth interviews (IDIs), key informant interviews (KIIs), and focus group discussions (FGDs) in two Tubiteho implementation provinces, Kirundo in the North and Bururi in the South. Through consultation with Pathfinder, the evaluation team selected one district in each province in which data collection would take place. The chosen districts were Mukenke in Kirundo and Matana in Bururi. From each district, one health center per commune was randomly selected for data collection (Table 1). In the North, Kirundo province and Mukenke districts were selected based on being remote in terms of access to health services. Additionally, of the three districts in Kirundo, Mukenke was the only one with a district hospital. In the South, Bururi province and Matana district were chosen based on their ease of access (ability to travel to all facilities) compared to the other regions. Further, the decision in the South was also informed by the fact that the context of this region was closely similar to the selected region in the North, which would facilitate comparison. The supported regions and selected provinces are shown in Figure 2.

Table 1. Selected study sites

Northern Region	Southern Region
Kirundo province	Bururi province
Mukenke district	Matana district
Gitobe commune: Health center A Bwambarangwe commune: Health center B	Matana commune: Health center C Mugamba commune: Health center D

Figure 2. Map of selected study sites in Burundi.



Data Collection

Desk review

The research team reviewed Tubiteho's quarterly and annual reports to identify project activities that correspond to the evaluation questions, particularly support versus strengthening activities, and activities related to service delivery for the five health areas. A desk review of other health-related projects concurrently operating in Burundi was also conducted. This review began with a list that USAID provided of their supported health activities. Other projects were identified through a snowball approach, through their mention in documents from USAID-supported activities, and an Internet search.

Research partner

D4I partnered with the Center for Population and Development Studies (Centre d'Etudes et de Recherche en Population et Développement; CERPED), a Burundi-based research firm, in the evaluation. A D4I team

member traveled to Burundi to work with CERPED on the initial evaluation design. Another member of the D4I team was present in Burundi for the training of data collectors and initial interviews.

Focus group discussions and interviews

FGDs were conducted at the communal level with male and female community members (the project's target participants) and CHWs who have been exposed to the program. KIIs with project staff were conducted, both at the central and district levels, with USAID representatives, project implementation staff (Pathfinder and their four implementing partners [IPs]), and Ministry of Health personnel. IDIs were conducted with provincial governors, provincial and district health officials, as well as district and health center hospital directors, healthcare providers, and GBV community focal points. Overall, 20 KIIs, 27 IDIs, and 12 FGDs with 90 total participants were conducted, totaling 137 participants. See Table 2 for a detailed description of the sample.

Table 2. Sample description

Format	Subject type	Number of subjects
Central level		
KII	Pathfinder: Chief of Party Deputy Chief of Party Monitoring and Evaluation director Technical Directors [4] Regional technical lead (North) Regional technical lead (South)	9
KII	USAID representatives	1
KII	PSI: Regional Director Malaria Technical Director	2
KII	Population Media Center Regional Director	1
KII	Ministry of Health officials [3]	3
Total central-level subjects		**16**
Provincial level		
IDI	Provincial governors	2
IDI	Provincial health officials	2
KII	Association Dushirehamwe representatives	2
KII	CEPBU representatives (Protestant Church)	2
Total provincial-level subjects		**8**
District level		
IDI	District health officials	2
IDI	District hospital directors	2
IDI	Ob-Gyn (MCH, FP, GBV) health providers General practitioners (all health topics)	4
Total district-level subjects		**8**
Commune level		
IDI	Health center directors	4
IDI	Health center-based nurses/midwives	9
IDI	GBV community focal points	2
FGD	Women beneficiaries	31
FGD	Men beneficiaries	31
FGD	Community health workers	28
Total commune-level subjects		**105**

Most interviews were conducted in person using an audio recorder with the assistance of handwritten notes taken by a member of the data collection team. The interviews with USAID representatives were conducted virtually, via Zoom. The data collection team included male and female researchers. Gender matching was not considered necessary for IDIs with Pathfinder staff, staff from IPs, and service providers,

as we did not expect sensitivity concerns around men interviewing women or vice versa. FGDs were conducted by paired facilitators (male and female) who shared note-taking and facilitation roles.

The data collection team consisted of eight data collectors and four supervisors from CERPED, and a research assistant from D4I. CERPED provided a four-day training for data collectors, focused on the following topics: evaluation objectives, research ethics and confidentiality, qualitative research method, the specific data collection tools, and how to prompt for more information from the study participants. The evaluation tools were pretested in Kirundo commune at the Kigozi health center. Feedback from the pretest was used to improve interviewing skills and make final adjustments to the interview guides.

Interviews and FGDs were transcribed in Burundi by the CERPED team and the D4I research assistant. The D4I team conducted a preliminary review of central level transcripts to develop preliminary results, which were presented to USAID in February 2024. A codebook was developed in French by the CERPED team through a review of provincial, district, and communal level interviews. Initial codes were deductively developed using the research questions as thematic categories (i.e., health areas, impacts, achievements, facilitators, barriers, lessons learned, implementation, sustainability, etc.). The codes were then inductively refined to facilitate a more nuanced understanding of the data. Transcripts were coded iteratively, and data were analyzed thematically, using the Dedoose qualitative analysis software. Commune-level data from the northern and southern provinces were analyzed separately in Burundi, by CERPED, using Dedoose.

Ethical approval was obtained from the Institutional Review Board Burundi (Reference #CNE/29/23). The Institutional Review Board in the United States (Tulane University) determined that the study was not human-subjects research (Application #2023-1622).

Study limitations included the lack of generalizability of findings to populations outside of study participants. To help ensure robustness of the qualitative inquiry process, we used triangulation of data collected from multiple informants as well as analyst triangulation through weekly meetings and desk review data to establish consistency in data coding and interpretation processes.

Results: Performance evaluation

Tubiteho's Routine Indicators

The Tubiteho project collected data on 63 indicators, targets for which it has mostly achieved as shown in the Appendix. However, data on some of the indicators are still missing as it relies on periodic data sources, such as the Demographic and Health Survey (DHS), over which Pathfinder has no control. In the program's fifth year, for the 44 indicators for which data are available, Tubiteho met 43 percent of its targets. Throughout the project life, indicators related to MCH showed the most progress, with this domain meeting at least half of its set targets, especially for indicators related to providing postnatal care to newborns. In the GBV domain, although trends alternate from one year to the next and noting that most of the indicators measuring progress in this domain are missing, targets to training CHWs in the management of GBV cases were consistently met for the majority of the project life. There are no noticeable trends in the nutrition domain; however, the three indicators dedicated to measuring progress in this domain were often met, but nutrition-specific indicators in other domains were mostly not met.

Over the course of the five years, the project often failed to meet its targets for the first intermediate results (IRs) and sub-results (increasing access to quality essential health services) with notable challenges in meeting targets for indicators in the malaria and FP domains. Data related to the second IRs (increasing the adoption of positive health behaviors) and sub-results is either missing or unavailable, rendering the assessment of progress made on set indicators difficult. Although achievements for targets related to the third IRs (strengthening health systems for health service delivery) and sub-results are evident from the numbers, the projects mostly failed to meet targets for indicators measuring improvements in management systems (M&E and data management) at supported health facilities and community levels. Further, targets related to service integration and strengthening supportive supervision at community and health-facility levels were never met.

The routine indicators provide information to understand the Tubiteho project's achievements over the past five years. These numbers should further be supplemented with the qualitative findings of the evaluation for a full and comprehensive understanding of Tubiteho's achievements, challenges, and lessons learned that could inform future program developments to address the health needs of Burundians.

Research Question 1a: To what extent did Tubiteho achieve its objectives for the three intermediate results and nine sub-results: Access to quality essential health services increased

Results on improving the availability of quality services are presented by health domain: family planning, maternal and child health, malaria control, malnutrition, and gender-based violence. Community-level data are presented separately for the northern and southern regions.

Family Planning Domain

Sub-theme 1: Health providers, community health workers, and local implementing partners were trained on the administration of family planning methods.

In the family planning (FP) domain, when highlighting interventions, respondents included that Tubiteho provided trainings for health providers and CHWs. Further, the project also worked within communities to

raise awareness about FP interventions and sensitize couples to select suitable modern contraceptive methods. Although both the northern and southern regions benefitted from interventions to strengthen health-provider capacity, the project implemented more on training activities for health providers in the South while activities in the North focused more on supportive supervision.

> *"The first thing was to accompany them, to coach them, and that was a certain practice of course, because capacity strengthening at local level is an ongoing process. And the other... You understand that we concentrated training in the South on FP, I say, and in the North, we concentrated [on] supervision. So, the other approaches, like the approach we were using to change, were more about strengthening health systems through training and supervision. We concentrated supervision in the North and the first year, I'd say in the South, training. Second year, third year, we did equitability." (Tubiteho project staff)*

Northern Region

In the North, participants recognized that training CHWs on different contraceptive methods contributed to FP awareness and education within communities. As a result, these CHWs have conducted sensitization campaigns within their localities, which are believed to have led to a reduction in close births and an increased use of modern contraceptives.

> *"It is noticeable that births that are too close together are tending to decrease significantly because contraceptive methods are being used at a high rate. This is thanks to the action of the CHWs, who have stepped up their awareness-raising campaigns in households." (Men's FGD, Health Center A)*

Contrary to claims by FGD participants that CHWs administer the Sayana injection in the community, this was not the case in all project implementation zones. In some localities in Kirundo, for example, CHWs have been trained but have not had any practical sessions to administer this method because community-level administration of this method is yet to begin.

> *"But as far as the administration of Sayana Press is concerned, we haven't yet received the go-ahead to start giving injections in the community, even though the CHWs have been trained. When the PNSR [National Reproductive Health Program] receives sufficient products and also when it gives us the authorization to start, at that moment, we're planning at provincial level a training period at CDS [health center] level, and we'll continue at community level." (Provincial Health Director, North)*

Despite these advances in FP reported by study participants in the North, the data collected shows that religious beliefs and husbands' opinions were still unfavorable to modern contraceptive use. The fear of side effects and subsequent possibilities of the husband taking on another partner were also cited as factors compromising acceptance of modern contraceptive methods. According to participants, modern contraceptives are given free of charge, but in the event of side effects, the providers who supplied them do not treat these effects, and the person concerned is forced to pay for the care associated with these side effects. Lastly, although most women were interested in FP, their husbands' disapproval often forced women to seek these methods without the partner's permission, which then became a source of conflict within the household.

> *"There are men who don't accept family planning using these so-called modern methods because they are administered free of charge; but after they have been used, they may develop a disease that*

depends on them [paying for it]. In order to be cured of this illness, money is spent. So, the husband forbids his wife to use the methods, saying: 'You're not going to create any problems in our household because you're using them for free, but if you fall ill as a result of using these methods, you'll have to spend money to be treated'." (Women's FGD, Health Center A).

"Participant 1: *Many men are against it, and we often go to the health facility to ask for these methods without informing the husband. But most of the time this causes a lot of problems because sometimes FP has harmful side effects on the woman's health, which means high costs for the woman's treatment.*

Participant 2: *They are against it because it leads some men into adultery when FP has harmful side [effects]." (Women's FGD, Health Center B)*

Southern Region

In the southern region, study participants said that to increase the availability of FP services, Tubiteho trained CHWs on counselling and administration of various contraceptive methods. The latter conduct awareness-raising sessions and provide contraceptive methods such as pills, condoms, and subcutaneous DMPA (Sayana injections) in the community. Women participating in the FGD testified that these efforts have led to increased acceptance and use of FP by couples. As such, the fact that CHWs can administer different contraceptive methods was considered a success in terms of improving access to FP services.

"Tubiteho has done a lot of important things: the fact that CHWs can provide certain care at home, distribution of the Sayana method at home by CHWs." (FGD Community volunteers, Health Center A).

"The training courses we've already mentioned were organized for health providers at BPS [Provincial Health Office], health-district, and health-facility level, such as the CDS. In the CDS, they were trained in contraceptive technologies. In addition to this training, they also have equipment related to contraception and especially the use of the suction cup, even if it is essentially used in the field of MCH. Otherwise, contraceptives are largely donated by the program, but the project contributes to training health providers in their rational use." (Provincial Health Director, South)

However, challenges persist that hinder access to FP methods within the region. The fear of side effects was often cited as a factor limiting the use of modern contraceptives. Further, although women recognize the benefits of FP, they are reluctant to use modern contraceptives because of the belief that adhering to these methods contradicts their religious beliefs.

"No, really no. We don't welcome these modern methods of family planning at all. Even at church level, they don't understand these things very well. So, me for example, when the community health workers start educating us to use these methods, I get up and leave because we can't agree on these things. We really can't! We've never heard of a woman using these methods who didn't have a disastrous outcome. We never have. Community health workers do their best to raise awareness, but I appreciate the role of community health workers, but on this subject, I'm wary of their message." (Men's FGD, Health Center C)

Sub-theme 2: Family Planning services were integrated with MCH and GBV services.

The integration of services, as was the fundamental principle of the project, was observed in the areas of

FP, MCH, and GBV. For instance, in the MCH domain, pregnant women and newborns receive a comprehensive package of services throughout the perinatal period, including advice on FP and access to contraceptives.

> *"…Pregnant women receive an integrated package of services. Because they receive packages. They receive the malaria services, and they receive iron supplementation services. They receive family planning advice, and they receive HIV services ... Women who come to give birth receive the usual maternity services. But at the same time, these women receive advice on FP; and if they want a contraceptive method, if they accept and choose, according to their choice, they can receive the contraceptive methods immediately. Which is really good for their health. When I talk about the post-partum period, I always give FP advice to those who haven't signed up for it, so that they end up signing up ... So, we really provide care from conception to delivery, and after delivery, we continue to monitor, and FP is integrated at all levels, at all these periods." (Project staff)*

The integration of FP services within maternal health services was confirmed in both the South and the North. Participants in both regions mentioned that this integration facilitated access to contraceptives for women who had just given birth and enabled providers to encourage pregnant women to consider which methods would be suitable for them after birth.

> *"I can give a specific problem in the case of FP. During supervision, they said that this service should be integrated into the maternity ward because when women give birth, it's more difficult to find the [family] planning service elsewhere than here in the maternity ward. So, they helped us a lot with coaching. When we set up the service, they helped us train our providers. If you set up a service and the provider has no knowledge, it can't be effective. They've trained the providers, and I can see that women adhere to the [FP] methods a lot before they leave the maternity ward, even afterwards." (District Hospital Physician, North)*

> *"Ok, I understand the question well, depending on the objective that brought you, depending on who welcomed you, a single service where we give it, we can benefit from others [...] Another example, when I'm consulting a patient and I find that she needs FP or that she has been a victim[1] of GBV, the care is immediately done in the same place. Here at the health center, among all the activities we have listed and in which Tubiteho supports us, we integrate services. Everyone can render any service where they are, but it's only afterwards that they will separate the activities carried out." (Health provider, Health Center C)*

While the project has tried to ensure that this integration happens across all implementation zones, a different approach had to be adopted for faith-based health facilities that were not ready to provide modern contraceptives. Because these facilities disapprove of modern contraceptive methods, the project lobbied for faith-based facilities to refer women needing these services to other nearby health facilities that had the capacity to provide access to modern FP methods.

> *"So, we tried, of course, to advocate, even if it meant that we could have some of the health facilities offering methods, all methods of contraception, whether modern or natural. And I'd say that's been a*

[1] In the context of the interviews conducted, the term victim is used to refer to someone who has suffered from GBV but has not sought medical care or legal actions.

real success. And even at Catholic level, I'd say it was a success because, after the advocacy meetings we held to resolve this challenge [...] we were still able to convince the clergy so that the health facilities, under their supervision, could refer clients who need modern contraceptive methods to the health facilities that offer them." (Project staff)

Sub-theme 3: Tubiteho provided the Ministry of Health with support in the distribution and transport of contraceptive methods.

To make contraceptive services more available, the project supported the distribution of FP methods across its intervention zones. According to project staff, the project worked with the Ministry of Health to provide transportation of contraceptives from Burundi's central drug purchasing agency's warehouse) where they were being stored, to health facilities in both regions.

"We also supported the Ministry's distribution of contraceptive methods to health centers. So, there were a lot of DMPAs, or rather cycle necklaces, which were stocked at CAMEBU – Burundi's central drug purchasing agency." (Project staff)

Initiatives aimed at reinforcing the availability of FP services, such as the training of healthcare providers and CHWs, the integration of FP services into maternal health domains, community-based awareness campaigns, the sensitization of religious leaders, and support in transporting contraceptives have had an impact on the accessibility and use of modern contraceptive methods. However, it should be noted that the administration of Sayana Press, much talked about in the interviews, is not implemented in all areas, according to testimonies recorded in the northern region, due to stockouts. In addition, the fear of side effects, the persistence of religious beliefs, and sometimes the preference for large families remain major barriers to the use of FP services.

Maternal and Child Health Domain

Sub-theme 1: Tubiteho strengthened the capacities of health providers and CHWs.

According to the Ministry of Health, the Tubiteho project made significant contributions towards improving the availability of maternal and child health services by strengthening community care, raising awareness, and providing technical support and training.

"What I can add is that the project helped us in the context of clinical mentoring in emergency obstetrical-natal care, i.e., it financed the missions of specialist doctors, gynecologists, obstetricians, anesthetists and resuscitators, pediatricians, and midwives who did descent missions in health facilities, hospitals, and health centers to strengthen the capacities of providers. So, it helped us with clinical mentoring in EmONC [emergency obstetric and neonatal care]. It also helped us with follow-up, post-training follow-up.... Overall, [hesitation].... I can say that... [silence]...the project has helped us achieve the program's objectives, in building our capacity to treat pregnant women and women in childbirth. But what I can add is that the funding was insufficient. Given the needs that we have at national level and the area that was covered by the project, I can tell you that it left us with a gap that needs to be filled by additional support, either from the same partner or other partners." (Program Director, Ministry of Health)

Further, the Tubiteho project ensured the availability of quality MCH services through training and capacity strengthening for health providers, CHWs, religious leaders, and local elected officials. Because the project observed a mismatch between the formal training that health providers in Burundi receive through their

medical education and the needs of the communities they serve, the MCH domain focused on making sure that providers have the knowledge and skills needed to handle different cases that they encounter daily.

> *"We have service providers who need to be strengthened in various areas. And I must point out that this is even a challenge. It's because the care provider in fact, the training curricula of our care providers in paramedical schools, in medical faculties, is that the curricula do not take into account the needs on the ground. Let me give you an example. We train, we implement an approach called PECIME. In health centers, it's the integrated management of childhood illnesses. But we find that in paramedical schools, this theme is not included. In other words, health providers have to be trained on the job. So, in all health centers, there is this need for training. I only gave the example of PECIME. Otherwise, there are other EmONC and BEmONC [basic emergency obstetric and neonatal care] themes." (Project staff)*

Northern Region

Respondents mentioned that the project has promoted training on maternal and neonatal health for health providers, including those working at community level. Additionally, it was also reported that the project had promoted community awareness and education on essential health practices that affect maternal and child health, such as hygiene and nutrition. By working at two levels of delivery (at the community level with CHWs and at the health-center level), the project improved access to primary health, particularly for the management of maternal and child health.

> *"We're taught how to monitor the mother from the moment of delivery and how to follow the child's progress. To prevent all the negative consequences that can occur during childbirth, and to prevent all the illnesses she can catch in the maternity ward. In a nutshell, these are the types of training we receive at BEmONC." (Health provider, Health Center A)*
>
> "Participant 1: *Pregnant women are well cared for and supported from the moment of conception right through to childbirth, the costs of which are fully covered.*
>
> Participant 2: *The availability of medicines [from] the CHWs and awareness raising about the use of [long-lasting insecticidal nets] have helped to reduce the frequency of illness, and we're delighted about that. Healthcare services are close to us; it's like being at home. At the hospital, there are fewer people seeking services compared to before the project." (Men's FGD, Health Center B).*

However, participants mentioned that household poverty and drug stockouts in health centers impact access to the treatments needed to manage cases of illness. Although treatment is free for children under 5 and for pregnancy and childbirth, study participants reported cases where drugs are not available in health facilities and patients are required to take prescriptions to pharmacies and buy essential medications out of pocket.

Southern Region

Interviewees from the South mentioned that the Tubiteho project has helped to strengthen healthcare providers' and CHWs' capacity. This training improved care for pregnant women, mothers, and newborns, particularly in terms of EmONC. In addition, the project conducted sensitization efforts on early prenatal consultations and the importance of maternal and child healthcare. Testimonies indicate an increase in the use of MCH services, including prenatal consultations, births attended by qualified personnel, and child vaccinations.

" .... In maternal and child health, we were taught many things, including BEmONC—basic emergency obstetric and neonatal care—to help women who come for childbirth. It also helps reduce maternal deaths. They trained first the trainers, then the providers, then the community health workers. This training has helped to reduce infant and maternal deaths. For example, at Matana hospital, we can go three months.... No! a whole year without registering a maternal death, whereas previously we observed the opposite." (District Medical Officer, South)

"Participant 1: *CHWs give certain medicines to children to treat diarrhea and fever.*

Participant 2: *Pregnant women give birth at health facilities.*

Participant 3: *Pregnant women consult health facilities frequently during pregnancy and until they give birth; even after delivery for their children's vaccinations.*

Participant 2: *CHWs teach them how to give children a balanced meal (the three kinds of food: proteins, fats, carbohydrates)." (Women's FGD, Health Center C).*

However, respondents mentioned that difficulties associated with household income and poverty hinder access to health insurance, prescription drugs, and ambulatory transport. As a result, pregnant women may find themselves limited in their ability to travel to health centers in case of need. Further, although trainings were conducted, the turnover rate of health personnel necessitated continuous trainings for new health providers.

Sub-theme 2: Health centers were provided with MCH medical equipment.

Northern Region

The Tubiteho Project supplied resuscitation equipment such as the "AMBU," a resuscitation device for newborns and adults. This equipment was used to save lives in emergency situations, particularly when newborn babies had difficulties breathing. In addition to resuscitation equipment, Tubiteho provided materials such as manual vacuum aspirators (MVAs), delivery tables, and incubators, among others.

"They intervened in the MCH department; someone told me that they gave MVAs, resuscitation equipment for newborns that can also be adapted for adults. In other words, the equipment they have donated can save mothers or children who are in danger, through resuscitation gestures and especially children who are ... very particularly after birth when breathing does not come spontaneously. These materials can save more than 60 percent of cases presenting early postnatal pathologies." (District Medical Officer, North).

"…There's the equipment; we've given equipment to almost every health facility. After consulting them, especially in maternal and child health. We've given materials: delivery tables, gynecological tables, incubators, and other things for small children." (Project staff).

Southern Region

Respondents emphasized that the project provided the health centers with medical equipment for MCH services. These included delivery tables, delivery boxes, resuscitation equipment, and more. Consequently, participants mentioned that access to this equipment has contributed to an improvement in maternal and child health outcomes and has limited the need to refer cases to other facilities.

"The Tubiteho project also gave us equipment. I told you that at the start, we only had one delivery table, but now we have two. So today we can accommodate two women giving birth at the same time." (Health provider, Health Center C)

"The same goes for equipment such as vacuum aspirators, which also help to reduce the number of deaths. Because if I've mastered the management of medical emergencies, I can't transfer a patient; instead, I'll take care of him myself. In the case of uterine rupture, for example, as I've been trained, I don't transfer. So that's an advantage. I do it immediately on the spot without there being any transfers." (General physician, South)

All in all, the Tubiteho project increased access to quality MCH services in the North and South, through capacity strengthening for health providers and CHWs and equipment support for health centers, which have led to improved care for pregnant women, mothers, and newborns. Consequently, participants in the North mentioned that they observed reductions in maternal and infant deaths. In addition, sensitization campaigns have increased the use of MCH services, particularly for prenatal consultations and childhood vaccinations.

Malaria Domain

Sub-theme 1: Capacity strengthening conducted for health providers and CHWs.

To facilitate access to quality malaria services, Tubiteho trained providers on malaria case management protocols and ensured that testing and treatment kits are available at the community level. In collaboration with the central and provincial level ministries, the project worked to address outbreaks and ensure that the necessary equipment is available. Although the project is not involved in the purchase of materials and medication necessary for the management of malaria, it has contributed to their availability by transporting them where they are needed. Through collaborations with the Chemonics project,[2] Tubiteho worked to ensure that essential medications are available in their intervention zones.

"And then, it supported training as well, primary training for CHWs, but also the project equipped CHWs with [the testing and treatment] Kit." (Program Director, Ministry of Health).

"Yes, to improve access to health. With the project, we set up... first of all, in terms of services, there have to be products. The inputs are not purchased by the project, but by another project called Chemonics, also from USAID, with whom we have collaborated, which provides the [...] concept of the project, it was they who had to buy the products to make them available in all the territories. And we had to make sure that these inputs were available." (Project staff)

Northern Region

Respondents in the North mentioned that the project has contributed to the training of CHWs in the early detection and rapid treatment of malaria in children under 5 and pregnant women at home. Community

[2] Chemonics has a USAID-funded Global Health Supply Chain project in Burundi, focusing on strengthening the country's health supply chain systems by ensuring availability and supply of health commodities such as malaria and HIV medication.

members recognize this progress made in the fight against malaria in the northern region and mentioned that services are readily available within their communities.

> *"In terms of malaria, here too, we have to start at the community level, and the project has supported us in training community health workers to be able to provide services at community level. That is to say, to carry out malaria tests and to know how to interpret these tests and to give medicines to people diagnosed with malaria. So that's the training already given at commentary level." (District Medical Officer, North)*
>
> *"And one thing that's special is that nowadays, as soon as you notice symptoms of malaria, you go to a CHW, and he does emergency tests. If he finds that it's malaria, he'll give you medication before the disease reaches a serious stage. Before, it was difficult to go directly to the doctors when you had a small concern, but now it's much more convenient to go to a CHW to discuss your health." (Men's FGD, Health Center B)*

Southern Region

Participants in the South highlighted that Tubiteho trained CHWs, health providers, and laboratory workers on malaria prevention, diagnosis, and case management. This training is believed to have improved access to malaria services at the community level, as well as early diagnosis and treatment in at-risk populations. Despite the progress made, challenges remain—particularly regarding the ongoing training of health personnel and the availability of the resources needed to combat malaria.

> *"In this area, the project has strengthened our capacities with regard to the new guidelines for malaria case management. It has also given us posters or guides containing the procedures for malaria case management; hence today, we find it easier in this area. Another thing is that malaria is now managed at community level by the CHWs. This was not the case at the outset." (Health provider, Health Center C)*
>
> *"There has been training on the new malaria management guidelines, but that was three years ago. There's another training session on IPTp [intermittent preventive treatment in pregnancy], guidelines for combating malaria in pregnant women. This IPTp training took place a month ago. But on the management of malaria, that was a long time ago. With staff mobility, this is becoming a problem. So many of the people already trained have been transferred." (District Medical Director, South)*

Sub-theme 2: The project adapted to the needs of communities.

Project staff mentioned that the Tubiteho project was sensitive to the needs of different communities. In times of epidemics, the project initiated mobile clinics to make health services more accessible to remote populations and to those facing a higher burden of malaria cases. This improved the project's responsiveness to epidemics/outbreaks, improving community-based management of cases. Lastly, in situations of concerning outbreaks, investigative missions were carried out to assess best approaches to handling these cases and to reduce their impacts on the population. However, these interventions were not uniform in all implementation zones. The South, being less malaria-endemic than the North, did not require mobile clinics.

> *"Tubiteho has always supported us in the implementation of mobile clinics. Eeeh, currently Tubiteho does not support us in the implementation of mobile clinics because we have strengthened community*

care. But this time, it is supporting us, reinforcing community care, and every time there is an abnormal situation, [there is] an abnormal increase in cases. But when we didn't yet have a reinforced community network, whenever there was an epidemic problem or a trend towards an epidemic, we detected the situation very early on, in collaboration with Tubiteho, and we responded to the increase in cases. All this is Tubiteho's support. We also carry out investigation missions. Investigation is a step in the management of epidemics." (Project Director, Ministry of Health)

Overall, the Tubiteho project has contributed to the fight against malaria by improving access to quality services through building the capacity of healthcare providers and CHWs and raising community awareness of malaria prevention and treatment practices. However, challenges remain that hinder progress in this domain. Health personnel attrition and ensuring continuous supply of equipment and medication in endemic areas were mentioned as barriers that continue to impact access to quality malaria services.

Gender-Based Violence Domain

Sub-theme 1: The project strengthened the capacities of health providers, CHWs, and community volunteers.

According to the project staff, several initiatives were put in place to improve the availability of quality GBV services. Implementing partners Dushirehamwe and CEPBU, who are both consortium members, were trained to listen to GVB survivors and accompany and welcome them to appropriate health facilities within 24 hours of a reported incident. Raising awareness of the importance of seeking help within this timeframe was emphasized to reduce the risks associated with unwanted pregnancies and HIV/AIDS. CEPBU members also received training on the health information system, including the collection, recording, and reporting of GBV-related data, enabling better monitoring of interventions and progress made. Further, health providers and community volunteers received trainings on how to manage GBV cases and ensure that they receive appropriate care. Community volunteers were also trained to raise awareness of GBV in the community and to identify potential cases. Lastly, trainings were also provided on how to report cases to the relevant legal authorities.

"In short, we have trained them [community volunteers] to raise awareness and refer them [potential cases] to the health center, and the health center does what is necessary, according to their level, and if there is something beyond their capacity, they make a referral to specialized centers that can do something else for them, or at the legal level." (CEPBU member, South)

"We have 38 communes within the project, so all the doctors, all the new doctors who were directors of these communal hospitals, we have trained. But we also have 13 district hospitals. We took on at least one doctor per district hospital. And so, we trained them for six days on the holistic management of SGBV, but with much greater emphasis on case identification. Because we found that many cases that come to hospital are not, they go unnoticed. So, we had to show these doctors, these nurses, how to identify a case of SGBV by the signs that present on arrival, who may come for treatment, for example, for a urinary tract infection. But you have to ask questions about how to recognize that it's GBV or something else. And so, we've trained all these people." (Project staff)

Northern Region

Interviewees in the northern region also showed that the Tubiteho project's contribution to the fight against GBV consisted of training and awareness-raising sessions for CHWs and community volunteers on how to care for GBV survivors and how to accompany them to seek legal services. In addition to case management, trained providers, CHWs, and volunteers conducted community sensitization on GBV to raise awareness and address myths and norms surrounding it. As a result, survivors were able to receive help at the community level.

> *"For our part, Tubiteho helped us with training. We've done a lot of training. There's another NGO that works with GBV. When we have a victim, we give her the minimum package to which she is entitled, i.e., medical treatment, care if she has been injured, HIV prevention, and prevention of unwanted pregnancy. Afterwards, we direct her to other sectors where she can be helped: legal at the OPJ [Officier de la Police Judiciare;* Judicial Police Officer*]] in Gitobe, psychological if necessary; there's a psychologist in Mukenke." (Hospital Director, Health Center B)*

Despite these encouraging results, there are also constraints that hinder the realization of Tubiteho's goals in increasing access to GBV services for persons who experience violence in the North. Community volunteers mentioned that cases submitted to the judicial authorities were not always resolved in a way that restores the survivors' dignity. It was also reported that local administrative authorities require volunteers to cover costs themselves when conducting community sensitization activities. Lastly, some community members undermined the work of community volunteers, stating that the volunteers had no authority to compel them to follow their advice.

> *"What are the main challenges you encounter in the course of your work?"*
>
> Participant 1: *The obstacles we always deplore is that our strength is limited to denouncing only. But unfortunately, the case closes without a good (tangible) result. The person who committed the crime (the guilty party) is never punished.*
>
> *[...]*
>
> Participant 2: *As we work with people of different characters, there are those who say that if we're the ones organizing the meeting, they can't come because they underestimate us and they say that we have no way of compelling them by fining them (we don't have a receipt) and that's why they can't participate.*
>
> *[...]*
>
> Participant 3: *What I can add is that you can tell a hill chief that you want to hold a meeting with the population about the Tubiteho project, and he tells you that you have to give him money first before you can initiate awareness raising in the community. As far as they're concerned, we earn money too. So, you have to give money before you can raise awareness." (GBV community volunteers, Health Center A).*

Southern Region

Interviewees in the South reported that the Tubiteho project has strengthened the capacity of health providers, CHWs, and community volunteers in community sensitization and management of GBV cases. Trained community volunteers have been made operational to identify cases of violence, refer them to

health centers, and provide first aid. They raise awareness of the need to denounce violence and help survivors to obtain medical and legal care.

> *"First of all, in the meetings we hold, we tell people that a victim of GBV shouldn't keep quiet so that it ends that way, that they have to talk about it so that we can get to know them and take them to hospital, then tell them where to complain so that the court can do its job. But first, we take her to the hospital for prevention against unwanted pregnancy and sexually transmitted diseases." (GBV community volunteers FGD, Health center D)*
>
> "Participant 1: *To the best of my knowledge, Tubiteho has trained CHWs; it's these CHWs who intervene by giving advice to people such as married couples who are in conflict.*
>
> Participant 2: *The association I know is Tubiteho, which has trained CHWs. When they see a woman or a man who has suffered gender-based violence, they approach them and give them advice. If they find that it's a case that's urgent, they connect him to a Tubiteho agent so that he too can intervene." (Women's FGD, Health Center D)*

The trainings improved access to health services for victims of GBV, by informing them about available services and the appropriate reporting mechanisms. These efforts helped to ensure that individuals affected by GBV have the courage to seek assistance and receive holistic treatment. Even male survivors have the courage to seek help without fear of being judged by the community.

> *"In years gone by, men were also victims of violence at the hands of their wives, so they kept quiet and couldn't complain. But with awareness-raising and encouragement to report SGBV, now even men can lodge a complaint. Now, the Kirundi expression that "Amosozi y'umugabo atemba aja mu nda" [literally: a man's tears flow towards the inside of his belly; meaning that a man must never externalize his pain]; this expression no longer works; even men can cry out for help and lodge a complaint. And it's a great innovation because the punishment inflicted on the man is equivalent to the punishment inflicted on the woman who commits GBV." (Women's FGD, Health Center D)*

Despite these encouraging results, persons who have experienced violence or rape are still quiet about the violence suffered, which impacts access to GBV services. The women's FGD participants expressed that they fear reporting GBV cases to authorities because society still silences survivors. For some women, fear of retribution—and the fact that most victims are dependent on the perpetrator and that the responsibility to take care of the perpetrator still falls on them if he is jailed—discourage them from reporting incidents of GBV through proper channels. Instead, they opt to seek advice through family members.

> *"We tell the family members. If it's the husband, we tell his family. You ask them to advise him because if you go to the authorities or justice and he's imprisoned, you're the one who's going to bring him food and you're also the one who's going to put more effort into getting him released. If you punish him, he'll see you as mean and that increases his anger. But you look among his neighbors for the one who is close to him so that he can gradually advise him." (Women's FGD, Health Center C)*

Sub-theme 2: The project provided transportation facilitation to GBV survivors.

Respondents mentioned that since most GBV survivors are economically vulnerable, the project has provided them with a transportation allowance to ensure that the inability to travel to the hospital is not a hindrance to seeking care. Through community volunteers who provide accompaniment, victims are

helped to get to health centers to receive care.

> *"Yes, for example, when I had a survivor to help and I didn't have any money, I could phone Bujumbura, and they would send me money on Lumicash[3] so that I could do what was necessary for that survivor. What's more, in the whole province, I've never heard a facilitator or focal point say they ran out of money to move their GBV survivor." (Dushirehamwe member, North)*

Northern Region

Participants in the North mentioned that they could always turn to the communal GBV focal points if they need to pay for GBV survivors' travel expenses. However, community volunteers mentioned that a transportation allowance should have also been provided to facilitate their work. Lastly, most GBV victims lack the financial means to afford health services and medical certificates, so providing only transportation facilitation was not deemed enough to increase access to care.

> "Participant: *If the victim has been sexually harassed or abused and is in critical condition, we have to pay the travel costs for her to see a doctor.*
>
> Moderator: *Do you get travel expenses for a victim? Do you still have any?*
>
> Participant: *When we have a victim who is in critical condition and doesn't dare go to the hospital or health center, we ask the focal point for travel expenses and if he doesn't have any, we travel at our own expense because we can't abandon the victim." (Community volunteers FGD, Health Center A)*
>
> *"There was no shortage of constraints. I said that we pay travel expenses for GBV victims, but when GBV survivors are referred from health centers to hospitals, we have to pay consultation fees. But also, to get the medical certificate, we have to pay money. This is a challenge because nowhere in the project does it say that we will pay for the medical certificate … we've already seen that the victims of GBV are truly vulnerable and have no financial means of their own. For example, it's very difficult to spend the whole day in hospital when you couldn't find anything to eat the night before. Even if we pay travel expenses, GBV survivors have other needs that we can't meet, such as consultation fees, payable medical expertise, and survivor catering." (Dushirehamwe Member, North)*

Southern Region

The participants in the South confirmed that Tubiteho provided travel expenses for GBV survivors who required support to travel to health centers. However, most interviewees pointed out that this intervention had its own limits. Interviewees emphasized that most GBV survivors were economically vulnerable and could not afford the cost of care associated with seeking GBV services, particularly the medical certificate required for a case to be prosecuted through legal avenues. Consequently, the package of interventions provided by Tubiteho in the GBV domain was deemed insufficient and participants mentioned that transportation allowances should be supplemented with covering the cost of care and certificates needed by people who have experienced GBV.

> "Participant: *[...] If one of the forms of violence we've just listed occurs, we take the victim to hospital with the travel expenses paid by the Tubiteho project. It's a way of helping them." (Community*

[3] Lumicash is a mobile financial services platform.

volunteers FGD, Health Center C)

"If we take a survivor of sexual violence to the hospital, we give him or her a ticket or travel expenses to get to the hospital because the victim is often poor and has no means of getting treatment. Unfortunately, we only receive the travel expenses. But even though the victim has had travel expenses, if I don't give him {money for] medical expenses, I will have abandoned him, since he can't afford healthcare. That's another problem!" (Community volunteers FGD, Health Center C)

Overall, the project's interventions to increase access to GBV services were multidimensional, encompassing sensitization and training for health providers, health agents, and community volunteers to ensure that appropriate care is provided for victims. However, in some areas, GBV survivors were still silent about the violence they have suffered, which means that the detection and management of cases is not entirely successful. In some cases, the services provided by health workers and community volunteers were not reported to the local authorities or the judiciary because survivors were scared of retribution. Lastly, the economic vulnerability of survivors meant that they did not benefit from healthcare that restores the physical integrity and human dignity that violence has stolen from them.

Malnutrition Domain

Sub-theme 1: Households were sensitized on good nutrition and feeding practices for pregnant women, mothers, and infants.

According to the project staff, Tubiteho worked to change infant and young child feeding behaviors. CHWs worked to raise awareness about balanced nutrition and monitored malnourished individuals within their communities. However, it was acknowledged that the project was not able to cover all aspects of malnutrition. Project staff felt that the nutrition component of the project was the least effective of the five domains supported by Tubiteho because the project did not provide therapeutic interventions for identified cases of malnutrition. Granted that this was not in their mandate/workplan, respondents believe that adding this component would have made nutrition interventions more effective. They mentioned that CHWs can only provide advice and are not equipped to manage serious cases of malnutrition. Thus, there remains a gap in ensuring more effective interventions to improve the nutrition status of children in Tubiteho intervention zones are conducted.

"[...]. Well, in this sense, in the sense of the insufficiency of resources, there is, there is a component […], which has remained uncovered, in any case for which I am not satisfied. It is the nutrition component. Of course, we have implemented activities to prevent malnutrition, promoting breastfeeding, promoting complementary feeding, promoting hand washing, fighting infections, because all this contributes to preventing malnutrition. We have trained and supervised health units, both in health centers and at community level, in screening for malnutrition. But that's all we've done. We've done almost nothing to rehabilitate cases of malnutrition.… Of course, cases of severe acute malnutrition are treated in hospital health centers, but cases of moderate acute malnutrition are almost never treated because they are not received in the health center. They are referred to the community health worker […] who does not have much support to take care of them." (Project staff)

Northern Region

In the North, interviewees mentioned that sensitization activities were carried out by CHWs on good infant

and young-child feeding practices, such as breastfeeding, healthy and balanced diets, vegetable gardens, and more.

> *"The community health workers look after the children. If someone has a malnourished child, they ask him to take him to the health center to receive cookies so that the child is as healthy as the others." (Women's FDG, Health Center B)*

However, participants felt that the evidence of change in terms of malnutrition was not reassuring. With many program participants being impoverished, respondents mentioned that limited financial means contributed to food insecurity. Therefore, understanding the importance of a balanced diet was not sufficient, given that participants could not afford to purchase diverse foods.

> "Investigator: *You could say that there's no change in malnutrition."*
>
> "Participant 1: *Change exists, but it's not perceptible. Many households are poor. People don't eat to their satiation to get the fats, proteins, and carbohydrates they need.*
>
> Participant 2: *There's poverty, people don't have enough to eat! The children are also malnourished. There are times when we sell what we've harvested and forget that we have to feed the family, including the children. When this happens, we tell ourselves that we'll buy what we eat at the market. Then the money runs out, and you're forced to look for odd jobs like plowing fields to buy enough to eat. In this situation, you eat what you can afford, not what you want." (Women's FGD, Health Center A)*

Southern Region

According to data collected in the southern region, CHWs were trained to sensitize communities on the importance of a healthy, balanced diet for children. Further, they regularly monitored children in the community for signs of malnutrition. Consequently, this was believed to have contributed to increasing access to malnutrition services at the community level and has reduced cases of malnutrition.

> *"We were taught how to prepare a balanced meal for our children (a meal that includes all three food families at the same time: lipids, carbohydrates, and proteins). What's more, as you can see, there aren't many malnourished children. But we used to meet many malnourished children whose mothers would take them for treatment or to get concentrates. Today, it's rare to find malnourished children here." (Women's FGD, Health Center C)*

Sub-theme 2: Malnourished children are screened and referred to health centers.

According to project staff, CHWs were trained to diagnose malnutrition and identify malnourished children, and then refer them to health centers for appropriate further care and follow-up.

> *"If we start on malnutrition, we've involved community health workers. They are the ones who go into the community, and they diagnose, and they look at the level of children or other people. When they compare the results with the norms mentioned on the charts they have and find cases, they refer the children who are malnourished to the health center for follow-up. At the health center, there are people who help and give them something to eat (therapeutic feeding)." (CEPBU member, South)*

Northern Region

According to interviewees, the project helped train CHWs to identify signs of malnutrition and refer

children requiring specialized care. By integrating the nutrition component within malaria services, respondents mentioned that health centers were able to supplement the screening conducted by CHWs. The project's integrated approach enabled malnourished children to be recuperated through other health programs, such as the fight against malaria, thus allowing for better identification and management of cases of malnutrition.

> *"So, it's, it's like an integration of services. So, we recover the children suffering from malnutrition via the malaria project, since the community health workers have the recommendation that every child who passes for malaria and for diarrhea, he should also be screened for malnutrition." (Chief Medical Officer, North)*

Southern Region

According to the respondents, CHWs conducted household visits to identify potential cases of malnutrition. Malnourished children identified through the activity were then referred to other projects/programs to receive nutritional supplements.

> *"Today, CHWs come into households to test malnourished children. They have tools they use to measure the child's height and weight to detect malnourished and non-malnourished children. If they find a child showing signs of malnutrition, we teach his mother how to prepare a balanced meal for him, as well as giving him fruit and any other kind of supplement for his diet." (Women's FGD, Health Center C)*

All in all, households in Tubiteho's implementation zones were sensitized to good nutrition practices and CHWs identified cases of malnutrition during their household visits. Cases of malnourished children were also referred to health centers for appropriate treatment. However, the project recognized that it has a gap to fill, as it did not provide therapeutic rehabilitation for children suffering from moderate acute malnutrition who were not treated by the health centers. In addition, household poverty limited individuals' ability to follow advice on good nutritional practices, including consumption of diverse foods.

Research Question 1b. To what extent did Tubiteho achieve its objectives: Adoption of positive health behaviors

Findings in this section are presented across both regions. Where results varied between the North and South regions, these differences are explicitly noted.

Increased demand and use of health services

The Tubiteho project made use of three awareness-raising strategies: mass media communication (i.e., radio campaigns), group education (i.e., waiting room education and community dialogues), and interpersonal communication (i.e., home visits). According to MOH representatives, awareness campaigns on the importance of health services and their availability have boosted demand for services. In addition, the decentralization and extension of health services is improving supply, which they perceive as stimulating demand. Health service data show an increase in the use of health services, indicating strong demand according to the Director of the National Health Information System Department.

> *"If I look at the rate of use of services at national level, and when I even go to these intervention provinces, I see, for example, that the rate of use of services has increased and more often than not exceeds 100 percent. In other words, there are children who come to the health center at least once, twice a month. This means that people don't stay at home; they still come to request services at the health facilities. This is based on the data." (Program Director, Ministry of Health)*

Community members shared the perception that awareness-raising and coordination activities generated interest in health services, encouraging early consultations. These activities were carried out together with the project and health staff at district and health-center level, in particular coaching, supervision, and follow-up of the performance of CHWs and health staff at health-facility level. Referrals to CHWs encouraged appropriate medical consultations, strengthening the link between patients and health services. CHWs were equipped to recognize symptoms of illness and recommend medical consultations, reinforcing their awareness-raising role in the community. Hands-on training improved providers' competence, increasing patients' confidence in health services. Increased trust in CHWs reduced self-medication and encouraged formal medical consultations. Positive outcomes, such as patient satisfaction and fewer deaths, have strengthened demand for health services. Health providers were trained to deal with rumors and misinformation about certain health services, boosting patient confidence and increasing demand. These combined initiatives have led to increased demand and utilization of health services in the regions concerned. For example, the provincial health director of Kirundo puts it in these terms:

> *"Firstly, it's something to be appreciated because now if someone presents with a fever, they go directly to a community health agent to be tested and if that's impossible, they're referred elsewhere. This has reduced the number of people who go to the traditional healers, and the death rate in the community has also fallen because people now have confidence in the activities offered by the community health workers." (Medical Director, North)*

The project has also improved the use of maternity services for early consultation. From a participant's observations, patients arrive for early consultation at the first sign of pregnancy-related complications. On the other hand, and despite progress reported, other government officials highlighted remaining challenges, particularly in the use of reproductive health services, underlining the complexity of creating demand for these services.

"If we look at programs like the reproductive health program, we can see indicators for childbirth, for example. We are still suffering in the use of ANC—prenatal consultation. Now, I can't say that this is strongly linked to the challenges of the project, since there are a lot of issues that come into play in order for there to be demand for the service." (Program Director, Ministry of Health)

Also, despite the evidence of changing attitudes to illness and increased service utilization, there are still community members who resort to self-medication and traditional healers.

"All (speaking at the same time): *There's no denying it. In our locality, there are those who consult healers before going to hospital, but there aren't many of them.*

Participant 1: *Eeeh! There are those who always start treating themselves with traditional medicines and then go to hospital when they notice that the patient's condition is becoming critical.*

Participant 2: *That's absolutely true, some people start going to the healers before going to the doctor; but the CHWs have organized a lot of community mobilization sessions to raise awareness among the population about adopting a habit of using health services in case of illness." (Men's FGD, Health Center B)*

Additionally, transportation to hospitals and health centers is also cited as a problem. Apart from the fact that, at least in one implementation district, only one ambulance per district covers a large area, some households are not economically able to pay the fee required to access the ambulance.

"Participant 1: *Another problem is the ambulance cards, which cost 2,000 francs each, that you have to have in order to be entitled to ambulance transport. These cards are often missing, even though transporting people, especially women, often requires the use of an ambulance. When you don't show this card, things get complicated, and the ambulance driver doesn't immediately agree to transport you. So, you negotiate the transport? This often happens, as the patient doesn't have the money to pay; he finds himself obliged to sell his possessions, the goat, the crops, go into debt... to pay the ambulance's travel costs. So, it's a problem on which other problems are grafted. Because, it's true, by paying for the ambulance you're solving the problem of your patient's health, but by selling your possessions or committing yourself to a debt, you're creating a new problem." (Men's FGD, Health Center C)*

In addition to household poverty limiting access to adequate health services, interpersonal aspects of quality of care continue to be poor. In some facilities, interviewees reported that providers show little esteem for patients who are treated with indifference and do not hesitate to go home, leaving service-seekers on the waiting list.

Changing gender norms to reduce gender-based violence

Project interviewees emphasize the need to change behaviors and mentalities to effectively combat GBV. They mention awareness-raising efforts at community level to challenge gender stereotypes and encourage men to adopt non-violent behavior towards women. They highlight an increase in the number of reported cases of GBV, attributed to victims' greater confidence in reporting abusers, as evidence of changing attitudes towards reporting GBV and a reduction in the stigma associated with victimization. It is emphasized that men, previously perceived as aggressors, participate in raising awareness in favor of the fight against GBV.

"But in concrete terms, what shows that there has been a change? Today, we have men who used to

mistreat their wives, but who have changed their behavior, and they are helping us to raise awareness among other men so that they too can change their aggressive behavior towards their wives. They come to give testimonies in public [...]." (Dushirehamwe member, North)

The training of community volunteers and CHWs has ensured that they play a crucial role in raising awareness and accompanying survivors to health and justice services. Clear referral systems have been established to ensure rapid access to medical and legal services for survivors, showing increased recognition of the importance of responsiveness and sensitivity to survivors' needs. These points demonstrate a gradual shift in gender norms in favor of reducing GBV. Survivors dare to talk about their experiences, illustrating a reduction in victim stigmatization.

"Now there's a change because victims of violence dare to talk about what they've experienced, whereas before they were afraid of being singled out and ashamed of what had happened to them." (GBV community volunteers FGD, Health center B)

"Participant 1: *We encourage them to speak freely without fear because many are afraid, but if we have been close to them and made them aware, they turn to us so that we can help the victim speak without fear and help them go to hospital and take their case to the courts." (GBV community volunteers FGD, Health Center C)*

Participants did indeed mention changes in the level of understanding between spouses as well as couples' behaviors within the household. As an example, one FGD participant spoke of the changes observed, using the story of a couple to illustrate how Tubiteho project's awareness-raising campaigns contributed to changing gender norms.

"Participant 1: *Cases of marital conflict have decreased significantly; whether it's the man or the woman, everyone knows that they have to contribute and take responsibility for their own home." (Men's FGD, Health Center C)*

"Participant 2: *The level of GBV has decreased because in the past, there were women who said they were forced by their husbands to have sex when they were drunk, but today these cases are no longer frequent because consent must prevail beforehand.*

Participant 3: *There have been changes because today, quarrels in households during the night have diminished significantly. What's more, today, if such a case arises, the person who did it can be summoned to explain, whereas before, no one would ask.*

Moderator: *Who asks him to explain himself?*

Participant 3: *It's the local administrative authorities." (Women's FGD, Health Center B)*

However, resistance to change still persists. A member of the Dushirehamwe Association who was interviewed speaks of some women victims who can seek medical services but cannot go as far as the judicial level at the risk of being rejected by members of the spouse's entire family if he is the perpetrator of violence.

" We can't say that we've achieved all our objectives. For example, we can't say that we know all the cases of GBV because to this day, there are women who tell us that if their husbands find out they've talked about what's going on in the home, they may beat them or repudiate them. Other women prefer to be treated only but refrain from going to court because if they go to court, they become enemies of

the husband's whole family and of her husband himself. For fear of this, they prefer not to go to court. As we give priority to the help they ask us for, we do it as they have asked us." (Dushirehamwe member, North)

Changing gender norms in favor of collaborative decision making for healthcare use

Participants report that decision-making authority is held by men but describe exceptions based on individual circumstances. Both male and female participants indicated that men often make the final decision on healthcare, yet they perceive clear indications that this dynamic is changing. Instances where women take the lead in decision making include when the man is absent or if the woman feels the man is irresponsible. In addition, the local government can play a role as an arbiter in decision making.

"Participant 1: *When someone is ill, the man may not be available at home for that moment. There, the woman may decide to bring the patient to the CDS. In the family the children too, in the man's absence, may agree and bring the sick child to the CDS. And at the CDS level, it's even possible that if they find that the illness exceeds their capacity, they may decide to refer it to the [redacted] hospital.*

Participant 2: *I'd like to add something to that. In families, someone, a child, can fall ill. And the wife, when she realizes that her husband is irresponsible, takes the situation lightly, this woman can decide on her own to bring the sick child to the health center; or she can invoke the local authorities so that it puts pressure on the man to bring the patient to the health center." (Men's FGD, Health Center A)*

Additionally, both female and male participants note that decisions can be made jointly, with a growing recognition of women's involvement in health decision making.

"Participant 1: *If he's available, it's the man who makes the decision to go and look after a family member. If the man is no longer available, it's the woman who takes responsibility and decides what's needed in the family, such as selling something to treat the sick person.*

Participant 2: *In a family, when there's agreement, it's the man who makes the decision after consulting his wife." (Men's FGD, Health Center B)*

These data suggest a move towards more collaborative decision making, where other family members, including women and children, have a more active role in the decision-making process. In short, notable changes in gender norms regarding health decision making are taking place.

Research Question 1c. To what extent did Tubiteho achieve its objectives for the three intermediate results and nine sub-results: Strengthened health systems

Development and dissemination of protocols, guidelines, and standards

Tubiteho IP staff reported that the project has contributed to the definition and development of protocols and guidelines and their dissemination in healthcare establishments, particularly in the South. They specifically cited protocols for voluntary medical male circumcision and medroxyprogesterone acetate, and guidelines for collecting data on both traditional and modern methods of contraception. The documents have been translated into Kirundi.

> *"I'm talking about FP. At the ministry level, we have supported the Ministry in the development, implementation, and setting-up of training protocols for certain domains; in particular the Tubiteho project has contributed to the development of the training protocol on VCC—VCC is voluntary contraceptive surgery, i.e., tubal ligation, vasectomy. The module is here. The trainer's module, the participants' module. All these modules. They were set up by the Tubiteho project. And the other thing the Tubiteho project did was to help the Ministry set up, implement protocols that had already been, strategies that had already been adopted by the Ministry but had no funding. Take, for example, the extension of subcutaneous DMPA [Sayana injection] delivery. This was done by the Tubiteho project at community level." (Project staff)*

Improving the client management system

The "client management system" refers to the processes by which patients are routed through a facility.

In the northern region, informants reported that the Tubiteho project had improved and streamlined the old client management systems in health facilities, which led to improvements in patient care. As an example, a participant commented on how care had to be improved by creating a bypass for survivors of sexual and gender-based violence (SGBV).

> *"For example, in the case of SGBV, sometimes before the Tubiteho project interventions, I'd say that victims were sometimes ridiculed because we didn't know that as soon as we met them at the reception services, we had to bypass all the other services to be able to refer them directly to a provider. Yes, that's really one aspect that I'd say has improved even the use of services for SGBV; because Tubiteho has strengthened the providers, the first one to see the survivor makes a short circuit to refer her to a provider, and the other routes are really, I'd say, in secret." (District Chief Medical Officer, North)*

In the southern region, the strategy was slightly different. Informants reported that quality improvement teams have been set up to oversee and improve the quality of health services. They expressed that improved quality has resulted in a decrease in referrals to other health facilities, as facilities were better prepared to treat the cases they received.

> *"We've noticed that referrals have been reduced because we can now take care of cases ourselves. Even slightly complicated deliveries can be handled without too much difficulty. There aren't enough calls to ask for help, and so on. In family planning, it's the same thing. A better-trained doctor is much more efficient. That's it." (General Physician, South).*

According to project staff, the improvements in the client management system improved patient flow and reduced wait times. They also described making improvements to facility-level data management systems

with a focus on improving data quality for better decision making regarding patient flow, facilitated by the quality improvement teams.

Strengthening the referral system

In the northern region, respondents focused their responses on referrals for people who had experienced SGBV. They reported that community members, including CHWs, receive training in referral to health services and the management of SGBV. Community awareness-raising initiatives were put in place to encourage people to seek medical assistance in the event of symptoms of illness and to report cases of SGBV. Health workers recognize the importance of appropriate referrals and the availability of medical equipment in the management of patients.

> *"Yes, well, I was going to mention another very global aspect; the referral/counter-referral system, which enables us to take... patients from the health centers to the hospital; and also to the hospital, from the hospital to a second referral hospital; so, the Tubiteho project has made its contribution since it also gives us fuel. Yes, fuel, which gives us better access to health facilities." (District Medical Officer, North)*

The CHWs interviewed in the focus groups confirmed their role in diagnosing cases of malnutrition in the community and referring cases to the appropriate structures.

> *"P3: We make home visits; sometimes we find a destitute woman and her children have been caught by the kwashiorkor because they're not getting enough to eat. We take the children and examine them with MUAC [mid-upper arm circumference]. If we find the color yellow, we transfer them to a nutritional center called* FARN *[Foyers d'Apprentissage et de Réhabilitation Nutritionnelle;* learning and nutritional rehabilitation centers*]. If the color is red, we refer them to the hospital. We proceed in this way, and it all depends on how the husband is unable to provide for the family." (CHW FGD, Health Center A)*

Informants in the southern region cited several interventions through which Tubiteho has improved the reference system. They include the use of a telephone line between health centers and hospitals to coordinate referrals, and the establishment of mechanisms to send health professionals where they are needed. The medical director of Matana district hospital described the dispatch of a qualified practitioner for a case of childbirth instead of transferring patients in difficult conditions. While treating the patient, the visiting practitioner is also training the health workers in the facility on how to manage the case.

> *"First of all, in addition to the telephone line between the hospital and the health centers, there's the referral system, where patients have to be taken by the ambulance. But maternity services also send a nurse or midwife to the health center when they call; the nurse or midwife goes to the health center if it's a case that needs to be managed there and he will teach the other nurses at this health center; he does it there, but if he sees that it's not possible, he takes the patient to the hospital. So, it also helps, if it's a service that these CDS nurses over there haven't mastered, he teaches it to them so that they can do it themselves the next time." (Medical Director & Head of Gyneco-Obstetrics, South)*

Informants mentioned that CHWs play a crucial role in the referral process, identifying cases requiring medical attention, referring patients to the appropriate services, and even accompanying patients to the facility.

> *"The project has contributed to a great thing because through these trainings of community health*

workers to care in the community, when they notice illnesses and they notice that there is an illness that they can't treat, they send [them] to the health center. They have transfer cards for each person and if it proves necessary, they accompany them to the health center before the illness worsens." (TPS & GBV Focal Point, Health Center C)

According to project staff, Tubiteho trained CHWs to recognize the signs of severe malaria and to refer cases to health facilities. Health facilities were also involved in the referral process, referring any cases to the hospital level when necessary. Tubiteho also introduced a mobile application called "Connecting with Sarah," which used SMS to facilitate referrals. The project also helped set up referral protocols from facilities that did not offer contraception to those that do.

The project's northern coordinator also mentioned fuel support for referrals.

"Another support is fuel support for referral and counter-referral. This reference and counter-reference is carried out by the district, thanks to our support." (Project staff)

Building a foundation for supportive supervision

Supportive supervision is "a process of helping staff to improve their own work performance continuously. It is carried out in a respectful and non-authoritarian way with a focus on using supervisory visits as an opportunity to improve knowledge and skills of health staff" (WHO, 2019).

In the northern region, informants explained that CHWs are generally supervised by health promotion technicians or service providers in charge of the community component. These providers are in turn supervised by district supervisors, and interviewees emphasize that the project has supported these supervisions, notably through joint missions.

"In all the areas I've mentioned, Tubiteho doesn't leave us alone. So, sometimes, they coach us in joint supervisions. They come, they take the district executive team with a team from Tubiteho, and then we go into the health facilities to be able to carry out a supervision, to realize whether the skills acquired through training are really being implemented. And the thing I appreciated about integrated supervision, integrated so the district managers [are] with the Tubiteho team, was that for us, we had the opportunity to realize what supervision really is. So, we saw that supervision before, district supervision - health training, it was a control, but not a supervision. Sometimes, it was even done in the office, and we'd say, 'How did you do that?' But with the Tubiteho project, when we did joint supervisions, it wasn't in the office, but rather in the departments. We'd say: 'We're going to the maternity ward. We're seeing how we've filed the forms for the FP beneficiaries; if there's an MIR syringe we've made available there, is it being used', is it, so it was formative supervision based on practical aspects. So, in another way, we were indirectly reinforced on the theme of supervision with these joint supervisions." (District Medical Officer, North)

"The CDS manager visits the CHWs to check whether we have filled in the registers correctly, or if we have any problem diagnosing malaria with a view to correcting it, or whether we are complying with workplace hygiene rules, and then rectifying it. We are encouraged." (CHW FGD, Health Center A)

In the southern region, informants explained that health center (CDS) staff make regular visits to CHWs in the various zones to assess their activities, offer support, and correct any shortcomings. In their view, this approach strengthens the monitoring of community activities and ensures the quality of the health services provided. CDS community focal points or health promotion technicians (TPSs) work closely with

CHWs, supporting them in preparing reports, resolving any problems encountered, and defining work guidelines. This collaboration fosters the transparency and effectiveness of community interventions.

> *"When we go to visit a community health worker, we take a form with us to make an assessment in the field because there's what we ask of him and what we observe and note without asking. We'll note what he's got, what he does perfectly. If we find him in any activity related to community health ... we can supervise and support him." (Community Focal Point, Health Center C).*
>
> "Participant 1: *CDS staff often come to visit us and check the storage sheets and registers. They check that we're filling them in properly, and they also check the stock of medicines we have.*
>
> Participant 2: *They come to visit us in the field and when we prepare the report, we do so in the presence of CDS staff." (CHW FGD, Health Center C)*

According to Tubiteho IP staff, there have been challenges in transferring responsibility for supportive supervision from Tubiteho to the districts. This was attributed to a lack of interest and to the small number of staff, especially at health district level.

> *"The Tubiteho team supports the districts, supports the operational level. But we introduce strategies; [there's no] ownership. In other words, when you're not there, they don't apply it. Because it's... well, at the operational level, meaning that these are people who have a lot of partners. And integration and appropriation aren't... Simply that, it's not something that's... Well, it's our system. [...] I even remember when we told them to follow the community health workers, they said, 'no. Why did they ask me to follow them? Why am I being asked for community data? We don't need community data.' Why didn't they? Because they didn't really see the point. And that's appropriation. Second, the other… challenge is also district level. They don't have a lot of staff, contrary to what people think." (Project staff)*

Research Question 2a: What factors facilitated Tubiteho's success in achieving its objectives?

USAID's prior work in the northern region

The successful implementation of the Tubiteho project in the northern provinces was largely due to its foundation on the prior Integrated Health Project in Burundi (IHPB), benefiting from continued funding from the same donor to enhance health services. Furthermore, the northern region's extensive experience with USAID made them more receptive and skilled in collaborating with the project, as noted by the maternal and neonatal health officer. USAID did not have a predecessor activity in the southern region.

"The northern region has benefited from USAID support for a very long time. For a long time. They were much more receptive. They already had, I'd say, experience with this support. It was easier to work with them." (Project staff)

Good collaboration within the Tubiteho consortium and with the Ministry and other NGOs.

The Tubiteho consortium's effective collaboration with the Ministry, leveraging strong relationships among members, created synergies. This teamwork facilitated resource pooling, expertise sharing, and coordinated efforts, resulting in enhanced outcomes and greater efficiency in implementing health interventions.

Collaboration with decentralized units enhanced support at the local level.

Collaboration with decentralized government units played a crucial role in strengthening local-level support for health initiatives, as noted by the PSI (Population Services International) staff below.

> *"The medical director of the health province is supposed to be the governor's health advisor. This means that if he asks the governor to do X or Y in relation to health, the governor doesn't hesitate to do it because he is his advisor." (PSI staff).*

Provincial health directors and district chiefs in the data collection areas also reported strong collaboration with the project.

> *"There is good collaboration. As I've told you, they've trained health providers, they've given material support to health facilities; and we organize supervision missions together, using their well-fueled vehicle, so I can attest that the collaboration has been good. The equipment they donated is now operational, and they are following it up, and the people trained are putting into practice what they have learned, so they are working well together." (Provincial Health Director, South)*
>
> *"We say that collaboration is everywhere, whether at provincial level, district level, health-facility level, or community level. What shows that there is collaboration is when they invite us, for example, to the data analysis meeting; everyone is present, and they follow the meeting and also correct a lot of things." (Provincial Health Director, North)*

The effective collaboration between the project and the Ministry of Public Health and AIDS Control significantly improved coordination, influenced health policies, ensured adherence to national guidelines, enhanced data collection, and strengthened the quality assurance of healthcare services. This was highlighted by one of the partners, PSI staff:

> *"And at the ministry level too, with this collaboration that is fluid, that flows, it enables us to raise our*

voice higher, so to be able to take into consideration what the project is asking for ... So, it allows us to influence the Ministry a little more. And I'd say that if we worked together with the project team, integrating the different departments through the various meetings, we tried to integrate the departments to be able to improve the services we provided. At the operational level, so that everything we do is improved, whether it's for malaria, FP, maternal health." (PSI staff).

At the central level of the Ministry of Health, participants maintained that the project worked well with the health units.

"The project has collaborated with the health facilities, for example in the case of mobile clinics, which are organized by the health facilities, which second staff to the community and seek additional providers to ensure good community coverage. The Tubiteho project works with the health centers on all these issues, by granting them the means, travel expenses, and fuel. If they didn't have fuel, we'd say, here's an envelope you can use to buy fuel. We equipped them with registers because the services provided at community level in the form of mobile clinics are notified separately from the services provided in the health centers. The registers we used were Tubiteho's support to the CDSs. That is to say, they collaborate with the health centers." (Program Director, Ministry of Health)

Finally, according to IPs, collaborating with local partners (NGOs) leverages locally available resources and expertise, thereby enhancing the project's impact and reach.

The integration of Tubiteho activities into the central ministry's action plans.

Integrating Tubiteho activities into the central ministry's action plans streamlined the implementation process and prevented duplication of efforts. By aligning Tubiteho's initiatives with the ministry's existing plans, resources and activities were better coordinated, reducing redundancy and ensuring that efforts were complementary. This alignment facilitated smoother execution, as both Tubiteho and the Ministry worked towards common goals, utilizing shared strategies and avoiding overlap in their programs.

In the northern region, planning activities for the Tubiteho project took local needs into account, such as the geographical remoteness of health centers and specific community challenges. Collaboration with local health authorities has improved M&E through regular progress meetings. However, concerns about joint planning remain.

"Yes, that is to say, at the beginning of the year, when we set our annual action plan, those who support us, we have to sit down together and say: I guarantee you, I'm going to do this at such and such a time; and that way we make a chronology of activities. Because sometimes, there are solicitations that are revised in light of other activities. We may be accepting for the benefit of the population, but it is not done as it should if it is done with another activity in parallel. Sometimes, we find that it's a supervisor who has to accompany them, perhaps, a team from Tubiteho at the same time [as] another team from another project. Sometimes you can't be in two places at once, yes." (Chief Medical Officer, North)

In the southern region, a district medical officer stated that the alignment of the project with the Ministry of Health's priorities demonstrates that the project is consistent with their own priorities.

"The objectives of the Tubiteho project align very well with our objectives because they align with the objectives or guidelines of the Ministry of Health. In the Ministry of Health, the main focus is on

maternal and child health. This means that if a project supports the maternal and child health sector, it normally makes a significant contribution to current national policy. That's why we really appreciate this project." (District Medical Director, South)

The provincial health bureau in the south reported that the activities implemented were integrated into the action plans of the supported peripheral levels.

"The action plan he gives us is integrated into the Concerted Action Plan. Otherwise at the BPS level, we have the PAA, [Plan d'Actions Annuel; Annual Action Plan*] which contains the routine activities of the BPS. But there is also the Concerted Action Plan, which contains the activities of the partners, that is to say they give us the annual outline of their activities divided into quarters. As their activities are divided into quarters, when we plan the monthly activities, we ask them the exact month in which this or that activity will take place, and they tell us the month and week. In short, we consult on the progress of activities." (BPS, South)*

The implementation of innovative techniques for behavior change communication.

Innovative methods, particularly the Sabido methodology, significantly enhanced behavior change communication by effectively delivering messages and fostering positive health behaviors. Using this internationally validated method enhanced the project's credibility and reliability, leading to better health outcomes in the target populations.

The Sabido methodology is "a powerful tool in public health communication" (Ryerson, 2012). Developed by Miguel Sabido, this proven entertainment-education approach leverages storytelling, particularly through soap operas, to promote behavior change. By featuring characters who model both positive and negative behaviors, it encourages audiences to adopt healthier actions. Widely used in the health sector for FP, HIV prevention, and other public health issues, its effectiveness stems from emotionally engaging audiences while subtly driving behavior change. The method's international recognition boosts the credibility of projects using it, leading to improved health outcomes in target populations.

"We have an international methodology. I don't know if you know a certain Miguel Sabido. He's an international who evolved [as a soap opera producer in Mexico and later, other countries in Latin America], and our president, Bill Ryerson, president of PMC [Population Media Center], [...] borrowed the communication of Sabido's methodology, which later became PMC's methodology and applied it in the health field." (PMC staff)In conclusion, the successful implementation of the project was largely due to the collaboration with the Ministry of Health and decentralized entities, as well as the active involvement of local stakeholders in the execution of USAID-funded initiatives. These factors were key assets in facilitating the project's progress.

Research Question 2b: What factors inhibited Tubiteho's success in achieving its objectives?

External factors

A high turnover rate of qualified health personnel and lack of equipment, pharmaceuticals, tools, and monitoring devices.

Human resource challenges significantly impacted the project's implementation. Frequent turnover of health personnel required ongoing capacity-strengthening efforts. Some facilities and service providers did not meet expectations. Increasing demand led to frequent stockouts, necessitating better coordination with suppliers. Additionally, a lack of basic equipment and unrepaired or unreplaced defective equipment due to insufficient maintenance budgets hindered health delivery.

In the northern region, women highlighted the issue of ambulance availability for urgent cases. The medical director in one of the Provincial Health Offices emphasized the inadequacy, noting that only one ambulance serves 20 widely dispersed health centers.

> *"This is related to the referral and counter-referral system: each district has an ambulance, and you understand with me that if a single ambulance works in a district with two communes, to make these routes with, for example, 20 health facilities by making transfers, it may be depreciated or break down. You hear that it's not enough, so we had to be given other ambulances." (Provincial Medical Director, North)*

Although trained providers are asked to share the knowledge that they have gained from training with those who have not participated, participants point out that they are overloaded and, therefore, unable to do so.

The number of CHWs was also insufficient to meet the needs of the population, particularly in regards to FP and home consultations. There were also difficulties in keeping records and generating reports, which hampers the traceability of activities and the evaluation of results. The Tubiteho project lacked sufficient technical staff to cover all implementation zones, with fewer than 20 staff members overseeing 309 health centers and 4,000 CHWs, making monthly supervisory visits challenging.

COVID-19 pandemic slowed down activities.

The COVID-19 pandemic impacted project implementation, necessitating constant adaptation of priorities and resources. Burundi officially reported its first COVID-19 cases on April 1, 2020, and additional cases emerged by July. Despite the pandemic, key events such as the USAID-AOR's final approval of the Tubiteho year-one workplan on April 30, 2020, and the presidential election on May 20, 2020, proceeded as planned. However, these developments contributed to delays, suspensions, and postponements in project activities, necessitating the creation of a catch-up plan to address the disruptions. Additionally, staff mobilization from Provincial Health Offices, district offices, and health facilities for election-related duties instead of project activities was identified as a problem. Also, the lack of ownership of project activities at district level and the problem of coordination of activities are presented as handicaps that hampered project implementation. The lack of coordination between the various ministerial programs was reported to have led to overlapping activities and conflicting agendas, necessitating better joint planning to optimize available resources. The interaction between community and CDS, and between CDS and district, which is not generalized even though the project supports fuel to ensure referral against referral at

ambulance level, is noted as a persistent difficulty. Interviewees pointed out that adequate financial and institutional support is essential to complement the limited resources of local health structures.

Fuel shortages hampered site visits and supervisions.

Fuel shortages disrupted site visits and supervision activities, preventing transportation to project locations and hindering effective M&E efforts. This affected the quality and progress of the project's implementation.

Delayed payment of CHW salaries due to a problem in the Ecocash payment system.

Payment delays for CHW salaries, caused by issues with the Ecocash payment system (a mobile money platform in Burundi that was used to disburse salaries to CHWs in the Tubiteho project), led to late salary disbursements, impacting employee motivation and project activities. The Ecocash system for paying CHWs failed in 2022, causing a 4–5-month delay in payments until an alternative was found.

Internal factors

The large number of indicators.

In terms of M&E, the project reports on a large number of indicators, even though it is faced with limited resources at both project and supported-structure level.

> *"One of the first challenges was the number of indicators that Pathfinder negotiates. They negotiated a large number of indicators. In other words, within the Tubiteho performance framework, there are mandatory USAID indicators. There are also other indicators for program management. That is to say, these are really indicators that are not mandatory for USAID, but they are indicators that will show the progress of the project in terms of quality of service and availability of services. There were a lot of indicators. The more indicators we collect, the harder it is to get good data. It was really a challenge." (Project staff)*

The slow approval of annual project workplans by USAID and the gap between the Government of Burundi's fiscal year and USAID's fiscal year complicated joint planning of activities. In financial terms, the budget remained inadequate in relation to needs, which complicated the planning of activities.

> *"Yes, that's right. When they do their planning, they share their planning with us at district level, at health-province level. Unfortunately, it's something they have to finish by June. But for us to be able to register it, we have to wait for USAID's approval. It takes a little longer to integrate this into their action plan, but that's fine. So, when we draw up our action plan, our plan, first of all, we look at the priorities of the district, the priorities of the health province. We're inspired by that. So, there's a good chance that what we produce is related to that." (Project staff)*

Summary of discussions from the evaluation's Data Validation Workshop: Challenges and limitations in project implementation

The evaluation team hosted a validation workshop in Burundi, in which they presented findings from the evaluation and solicited feedback from participants. The USAID Mission and Pathfinder developed the invitation list, which consisted of representatives from the Ministry of Public Health and the Fight Against AIDS, provincial administrators, Tubiteho IPs, other health-focused partners operating in Burundi (both local and international), and USAID Mission staff.

During the data validation workshop, participants reported the following limitations to achieving project

implementation. In the northern region, informants noted that Kirundo has an un-targeted population living on the island of Rweru facing several challenges including a lack of health facilities and transportation to reach the population. There is a pressing need to develop a national strategy for community-based interventions.

In the southern region, in Bururi, it was noted that project participants needed to be included in the planning process and that follow-up was necessary for the activities conducted in the locality. Additionally, fuel availability was a significant issue. For Rumonge, the administration reported a lack of a joint planning approach at all levels (district, provincial, and national). Additionally, there were no "before-and-after" survey results to show clear changes at the end of the project, and no midterm evaluation was conducted to assess the project's implementation.

A nutrition specialist from United Nations Children's Fund (UNICEF) noted that there was no funding allocated for nutrition. In cases of malnutrition, children were screened but not treated. Malnutrition, social protection, health systems, education, water, hygiene, and sanitation are all interrelated, making it essential for all stakeholders to be involved. Additionally, strengthening coordination with other stakeholders in the same area is crucial.

Other health projects operating in Burundi

There were many health projects that operated concurrently in Burundi during Tubiteho. These projects, particularly those that operated at the national level or within Tubiteho-supported provinces, may have contributed to Tubiteho's success in reaching its quantitative targets. While the qualitative data collection was focused on Tubiteho's activities and impacts, it may have been difficult for respondents to distinguish between different projects, particularly those with USAID support.

In addition to Tubiteho, USAID supported three health projects in Burundi. The first was the MOMENTUM Private Health Delivery project, which focused on increasing demand for and quality of private maternal, newborn, and child health; voluntary FP; and reproductive health and malaria services. MOMENTUM operated in five of the six Tubiteho provinces. While MOMENTUM likely impacted population-level health indicators, the fact that it primarily worked with the private sector means that its impact on the public-facility indicators that Tubiteho reported was probably limited. The two projects did meet periodically to coordinate their efforts.

USAID also supported the Global Health Supply Chain Program-Procurement and Supply Management project, which was implemented by Chemonics. This national-level effort focused on the supply chain of vital health commodities. According to their annual reports, Tubiteho coordinated with Chemonics to address medicine stockouts.

Lastly, USAID funded Gir'iteka, implemented by the Society for Women against AIDS in Africa-Burundi with support from Engender Health. Gir'iteka was designed to integrate SGBV prevention and response into HIV treatment and prevention programming. It was implemented in one Tubiteho province, Kirundo. Tubiteho also coordinated with Gir'iteka, developing joint workplans to address SGBV.

Another notable health project was the World Bank's COVID-19 Preparation and Response Project (2020–2025), which gave US$65 million in support of performance-based financing, the national free care policy, immunization, training, and equipment.

Burundi also continued to receive routine support for MCH from UNICEF, and routine support for HIV, TB, and malaria from the Global Fund. The Japan International Cooperation Agency (JICA) supported emergency food aid to Kirundo (a Tubiteho province), and Médecins Sans Frontières provided trauma services, mass casualty preparation, and malaria and cholera outbreak response between 2021 and 2023, although this support was not concentrated in Tubiteho provinces.

Table 3. Other Burundi health projects.

Project Name	Donor/Implementer	Focus Area	Geographical Coverage
Tubiteho	USAID	Public health services, family planning, reproductive health, maternal and child health	6 provinces
MOMENTUM Private Health Delivery	USAID	Maternal, newborn, child health; family planning; reproductive health; and malaria (Private sector)	5 of 6 Tubiteho provinces
Global Health Supply Chain Program-Procurement and Supply Management	USAID/Chemonics	Health commodity supply chain management	National level
Gir'iteka	USAID/Society for Women against AIDS in Africa-Burundi	SGBV prevention and response in HIV treatment and prevention	Kirundo province
World Bank COVID-19 Preparation and Response Project	World Bank	COVID-19 response, performance-based financing, free care policy, immunization	National level
Resilient and Sustainable Systems of Health (RSSH)	World Bank	Resilient and sustainable health systems	National level
UNICEF Maternal and Child Health Support	UNICEF	Maternal and child health	National level
Global Fund HIV, TB, and Malaria Support	Global Fund	HIV, TB, and malaria prevention and treatment	National level
JICA Emergency Food Aid to Kirundo	JICA	Emergency food aid	Kirundo province
Médecins Sans Frontières	Médecins Sans Frontières	Trauma services, mass casualty preparation, malaria and cholera outbreak response	Various locations (not Tubiteho provinces)

Research Question 3: How have local perspectives been integrated into Tubiteho's planning and implementation, and how do they view the project?

Taking local perspectives into account when planning and implementing a project, from national to subnational to community perspectives, is crucial to its effectiveness and impact. When the Tubiteho project was conceived, it was understood that its interventions would vary according to needs and context. Thus, analysis of the final data from the IHPB project was to form the basis for planning in the North, while a more comprehensive baseline assessment was envisaged in the South. Behavior change interventions at provincial and district level, in both the North and South, were to be context-specific, targeting the behaviors of both end-users of services and service providers.

A desk review of project reports from 2020 to 2022 shows that the project has collected data at community and health-facility level to understand the local realities on which interventions can be based. These include health assessments and audits (evaluation of health facilities, audit of indicators of violence against women, audit of malaria-related deaths, and maternal health audits), and data collection and analysis (household survey and data analysis, rapid assessment of health facilities, and evaluation of specific programs).

Project staff claim to have adopted a participatory and collaborative approach with local stakeholders and Ministry programs such as the National Reproductive Health Program (PNSR) and National Integrated Malaria Control Program (PNILP), integrating activities into other existing activities. They emphasize that local officials, CHWs, and other actors have been involved in the planning and implementation of interventions, and that communication and exchange mechanisms have been put in place, including coordination meetings, to identify challenges, make decisions based on data, and share progress and action plans with the community. These meetings bring together the various stakeholders, including community representatives, as confirmed by the project's southern regional coordinator. According to the project staff, the planned activities are based on priorities at peripheral and intermediate levels.

> *"In these meetings, it's mainly our implementing partners; here I'd say the Provincial Health Offices, the health districts, the heads of the health facilities, and then at the community level, there are also the implementing partners at the community level. They're always invited to exchange on achievements." (Project staff)*
>
> *"When we make our action plan, our plan, first of all, we look at the priorities of the district, the priorities of the health province. We are inspired by that." (Project staff)*

Project staff also point out that they used the Community Scorecard to involve the community in identifying local health problems and formulating action plans and interventions tailored to the feedback and needs expressed by local communities. However, this approach did not work, seemingly due to a lack of engagement by local community members, and the project was forced to abandon it. However, the staff also talked about integrating local perspectives through community dialogues to identify needs.

> *"We go to a community…. Well, first we have a preliminary meeting with all the members of the community. This is to introduce them to the strategy, and then we group them, we group the community according to, depending on certain specificities, the community health workers separately; the administration, the grassroots administrators, apart from the members of the community; the other members of the community, perhaps pregnant women, nursing mothers apart, perhaps men,*

fathers apart. And then we submit a questionnaire to them to, in fact, identify the health problems they have in the community and by identifying these health problems." (Project staff)

According to the FP manager, contacts were made with the central administration and program managers at the Ministry of Health, and provincial workshops were organized with the provincial authorities to inform them of the project and obtain their feedback on the priorities, with a view to taking them into account.

"And then we did workshops in the provinces to meet the governor and so on. So, we got to know the project, but the feedback was to give us their priorities. So, it was these priorities that we used to plan activities for the years of the project." (Project staff)

Project staff affirm that project managers have taken into account the needs and wishes of local communities. Meetings with the project's IPs, whether to share results or information about the project, and data collection in the community to identify needs are the strategies used to take local needs into account when planning interventions.

At the community level, interviewees' and focus group participants' perceptions differ by region. In the northern region, CHWs and community volunteers supported by Tubiteho, who in principle are affiliated to a health facility, affirm that they are consulted in the activity planning process for the health facilities under their jurisdiction, yet they are not involved in decision making. As for the healthcare providers who expressed themselves, they cannot say that they were approached by the project to give their opinion in terms of needs, but they consider that their needs are taken into account as long as the project touches on areas of great need.

"The fact that the project intervened on several fronts coincided with the CDS's main priorities. What's more, if you work on MCH, FP, nutrition, malaria, and SGBV, you're touching on the main challenges to promoting the health of the population." (Health provider, Health Center A).

At the district and community level, participants in the northern region noted that it was important to take into account local needs, and the activities of the various partners should be integrated into the action plans of the supported health facilities and districts. However, the district chief of Mukenke and the medical director of the Provincial Health Office expressed concern that they had not been involved in the planning of activities.

"I would say that there was never any joint planning because if there is joint planning, that's where we bring in the priorities. As I've already said, there are provincial priorities that aren't realized, but if you work together, you share results […]. Another thing is that in some places, the work on fuel, for example, the referral/counter-referral system suddenly stops without any meeting with us, and the fuel for the supervisions stopped directly without warning us, even though we were at the beginning." (Provincial Health Office Director, North)

Interviewees did not reveal any action taken to identify needs at health-facility level. On the other hand, at district level, service providers mention working in synergy. The providers who expressed their views stressed that the support they received met their needs. They emphasize support for medical equipment. Others point to the collaboration with the Tubiteho project as evidence that the project is taking local perspectives into account in its implementation.

"We work closely with the project staff, if there is a problem, we can discuss together and find solutions. We do data analysis quarterly, and if there are challenges, we find solutions together; there is joint supervision." (District Chief Medical Officer, North)

It should be noted, however, that in addition to community members who were unaware of the project, some providers claim to know nothing about the Tubiteho project.

"I don't know much about the Tubiteho project. I've already told you that I can't distinguish everything that's being done today whether it's the gift of the project or of the ministry in charge of public health. So, it's becoming complicated for me to answer because I don't know how much comes from the hospital and how much from the project. It's really beyond me." (District Hospital Physician, North).

Activities implemented in the southern region are integrated into the action plans of the peripheral levels that are supported.

"The action plan he gives us is integrated into the Concerted Action Plan, otherwise at the BPS level, we have the PAA [Plan d'Actions Annuel; Annual Action Plan*], which contains the routine activities of the BPS. But there is also the Concerted Action Plan, which contains the activities of the partners, i.e., they give us the annual outline of their activities broken down into quarters. Given that their activities are divided into quarters, when we plan monthly activities, we ask them for the exact month in which a particular activity will take place, and they tell us the month and the week. In short, we agree on how the activities are to be carried out." (BPS, South).*

However, district-level participants identified difficulties in joint planning. As the project does not provide information to the partner on the budget allocated to the activities it is going to implement, when the health facilities or districts draw up their action plans, they cannot integrate an activity that is not budgeted for into the plan, and this constitutes an obstacle in terms of sharing the information needed to plan properly.

Community health workers as well as male and female community participants claim to know or have heard of the project. With the exception of women participants in the FGD in Health Center B who had heard of the project from CHWs but knew no more about it, other participants affirmed that the project takes into account local perspectives and needs, notably through the identification of their health needs and challenges. CHWs claim to be involved in the planning and decision-making process at health-center level, enabling them to voice the needs of their community. Health providers and health managers at district and provincial level also affirm that the project's collaboration has identified needs and intervened on the basis of needs and challenges encountered in the community and in the health facilities. Because of meetings and supervision visits in the community, needs are identified, and interventions take them into account.

"They're collaborative people. They would come and talk to us before doing anything. The Tubiteho project collaborated with the structure agents. We'd tell them: there's a problem in maternal and child health, the problem in FP, and I think they'd put it into their planning." (District Hospital Director, North).

Despite the assurances of joint planning with the PNSR and PNILP, a Ministry of Health staff member described the project's lack of flexibility, not allowing for adjustments to what is already planned.

"Perhaps the difficulties we encountered were that the project wasn't flexible. We couldn't plan

anything outside of what was previously planned (by the Tubiteho project). Adjustments were difficult to make within budgets. Basically, that's it.... Joint planning means that the Ministry, at the delivery level, has an action plan and interventions included in its action plan. The Tubiteho project also has activities in its action plan. The problem we've always encountered has been inflexibility in planning. This means that when I say: We have planned this, and we want it to be carried out! They say: Aah! We have a budget for this.... By the way, I want to say that the project has its objectives, and the government has its objectives. We wanted all these objectives to align completely. In this case, we'd say the partnership is total. They may have funding, but this funding doesn't help us much to improve the quality of health information.... Sometimes, we have to fit into their planning. We try to be flexible; they're not flexible at all. That's what I hear about the project." (Director of the National Health Information System Department)

The data provided also sometimes reveals a gap in communication about planned activities. A PNSR staff speaks of cases where he was informed with little notice of activities planned by the project.

"Sometimes, there were planned activities to which we were informed at the last minute. The organizers of these activities were asking the PNSR for resources. Now, we've asked (suggested) that there be improved collaboration for future projects." (Program Director, Ministry of Health)

Research Question 4: What are the plans and prognosis for sustainability after the project ends?

When designing the project, it was understood that the project should identify opportunities to mobilize funds, and to coordinate and collaborate with other funders and implementers to increase the likelihood of continuity of interventions over time and the expansion of effective interventions. In addition, given the activity's focus on changing behavioral norms, both in the community with regard to health-seeking behaviors and in the health facility with regard to adherence to guidelines and other aspects of quality, the project had to act in such a way that its interventions would have a lasting impact on health. As innovation and technology have improved the use, access, availability, and quality of health services over the past two decades, the project mandate included building on successful innovations both within and outside Burundi and using innovative technologies and strategies to support the achievement of the three intermediate outcomes. Interviews with project staff, however, did not reveal any explicit plan or strategy, or any actions specifically aimed at the sustainability of interventions, despite the project being asked to draw up a sustainability plan.

> *"I think also we asked the IP to submit the sustainability plan at the beginning of the project. But no, I don't know if like, maybe at the end of the project [it] would be good to review that sustainability plan to see where it stands." (Former USAID AOR)*

Interviewee responses that illustrate the participants' perceived potential for sustainability of Tubiteho project interventions are based on strengthening health providers' skills, supporting health facilities with medical equipment and materials, maintaining the good practices and innovations initiated by the project (such as data analysis meetings), and advocating for the integration of these good practices into national guidelines. At the time the data were collected, the project was still advocating to include project strategies in national guidelines, so this was not yet achieved.

> *"For sustainability, ... we are influencing, advocating so that the strategies we have used are put into national guidelines. Because this can continue. Yes, that's right. It's something we're, we're going to do as part of the sustainability of this project, today, in terms of monitoring and evaluation." (Project staff)*

Ministry of Health personnel similarly highlight strengthening providers' skills to offer quality healthcare and to collect and use quality data, support for medical equipment, and recommendations resulting from the evaluation of documents and studies carried out, as well as best practices, particularly innovations in malaria management and the use of data. These project activities are perceived as contributing to eventual sustainability of program gains.

> *"I can say that we can sense something of sustainability. If we've organized capacity-strengthening workshops on data use and quality data production, I'd like to point out that our National Health Information System Department already uses an online platform.*
>
> *People have learned good methods and practices to ensure data production and quality assurance themselves, thanks to the training we've provided. When we have trained people at the peripheral and intermediate levels, it's not to say that every time the central level has to go up [to the field] to further reinforce. It's the same at the intermediate and DS [health district] levels. The support we have given concerns the transfer of technical skills, even intellectual skills, to ensure continuity and sustainability, at least for health information management. We're not afraid that if I'm not in the district office, in the*

health province office...that the data won't go up [won't be transferred to the central level]. The data reaches us.

Today, when I visit the base (to say if I check in the database where the data are stored), the data are there and updated. This is an aspect of sustainability." (Director of the National Health Information System, Ministry of Health).

Moreover, in participants' opinions, the knowledge and good practices acquired by the providers, whether at community, health-facility, or district level, will continue to be applied even at the end of the project, and the equipment supplied will continue to function even after the project's end. According to one participant, the funds provided by the community-based performance-based financing (PBF) will ensure that CHWs have the tools and materials they need to continue their activities. As for referrals, they believe that with the help of community contributions, districts will be able to renew ambulances to continue to provide referrals.

"The kit [of supplies and materials] they've received may be finished at any moment, but as they provide care, there's community-based PBF. So, they get a bit of money and even if the equipment they've received runs out, they can buy replacement equipment. ... There's the community contribution that we're continuing to make, and even the Tubiteho project has helped us to categorize the population in relation to the referral-to-referral system contribution.

So even if the project comes to an end, the referral vs. counter-referral will continue to operate because today, for example, the Kirundo district hospital already has the money to buy another ambulance, thanks to the community contribution and also the 5-percent PBF deduction at health-facility level ... because there will come a time when the community will see that the ambulance is good for them, and they'll have to keep contributing.... If the Tubiteho project helps us to equip the rooms with chairs, an overhead projector, or a flat screen, it will help us to analyze the data easily, and on top of that, in Kirundo, there's a fiber optic cable that runs very close to BPS with the beginnings of a working Internet connection.

We think that, as a provincial authority, in a few days' time we'll be doing data analysis online, and that will help us a lot. To summarize what's involved in data analysis and to make the project sustainable, they can help us equip the meeting rooms, and we'll analyze the data." (Provincial Medical Director, North).

Other participants felt that working with the health district, Provincial Health Offices, and the Ministry of Health's central programs was a guarantee of sustainability. The good practices initiated by the close collaboration with PNILP in the management of malaria are also considered to be sustainable in improving the fight against malaria.

"The sustainability, Tubiteho's interventions, I think they're going to gain from a sustainability... to a certain degree because really, we have to be honest anyway. When a partner leaves, he leaves with something, but the continuity of Tubiteho's support is back in its place.

When I say that Tubiteho works with the whole program, I mean that everything they do with the program stays with them. For example, when Tubiteho evaluates the IPTp strategy, the document remains.... The documents they've produced are the evidence that's there. We are currently working on this evidence.... If Tubiteho, who supported the IPTp evaluation, recommends that IPTp should be extended to the private sector, then all I have to do is implement IPTp in the private sector, and we'll be

on our way... Tubiteho is staying because we were together on the recommendations made by its investigations.

Tubiteho, when it set up... when we implemented [community case management of malaria] in the provinces of Muyinga, Kirundo, Karusi, and Makamba, after it left, the machine stayed. There are no problems because the equipment…when Tubiteho leaves, the community health worker who is already equipped with tools for storing medicines and screening tools... the kit stays. ... It's true, Tubiteho provides us with financial support.... When it leaves in terms of program funding, there's something that goes, but this same set-up from Tubiteho encourages us; it helps us to show the gap to USAID to fund other similar projects." (Program Director, Ministry of Health)

There are, however, structural problems that may hamper the continuity of activities once the project has ended. Rapid staff turnover and work overload have already led to the loss of healthcare providers that have been trained by the project, which likely compromises the capacity-strengthening approach as a whole, as well as the capacity to train newcomers. Further, the maintenance of the equipment supplied requires a budget that is not available in the health facilities, and there are no prospects for the renewal of this equipment. A provincial doctor points out that they still need the support of the project because even what is supposed to be sustainable requires follow-up and support.

"In fact, what's the problem I've found? The retraining and equipment they've given us requires maintenance. All this requires resources that often don't exist without the contribution of our partners. So, we're short of resources because our means are limited and can't cover all our needs. Even retraining requires resources, and all the equipment they've given us requires resources. It's not a question of saying they can stop; they'll probably have to! But the equipment they've donated won't last forever, and their lead times are also limited. Trained staff may also leave their departments. Training will always be necessary, and that will require resources. That's why we still need them." (Provincial Medical Director, South)

Additionally, the project's IP has not developed partnerships with other organizations or donors to continue supporting activities initiated in its intervention zone. Meanwhile the lack of ownership of activities at peripheral level means that it is not possible to confirm that activities carried out with the project—such as joint supervisions and even patient referrals—will continue, as these are activities that the project supported financially. Further, provincial health directors, whether in the North or South, continue to request support at their own level (i.e., supervision vehicles and meeting room equipment). Tubiteho staff are also concerned about ownership of project activities at the various levels of implementation. One interviewee addressed ownership of the project's achievements.

"[Ownership] depends from district to district. You can't generalize it because it's linked to leadership. It has to do with personality; it has to do with the dynamics of the team. You can't just put them on the same level. It even has to do with the geographical location of some.... But when we talk about appropriation, everything comes first from the Ministry, so at different levels. And when ownership isn't there, forget about it. You can't talk about ownership at every level." (Project staff)

This concern is shared by national government officials, calling out a lack of ownership at the health district level.

"At district level, really, appropriation is not optimal, in my assessment, appropriation is not optimal.... In the sense that there are interventions that have been supported by Tubiteho, but afterwards we

don't see the districts taking over. For example, I mentioned that Tubiteho was supporting the implementation of home-based care. In principle, the health districts were supposed to. I don't know if when you talk about districts you mean the district health office or I'll say in general, including its health centers. In principle, they should take over and supervise community health workers in terms of drug management, malaria diagnosis, and so on. In terms of health information management, but really the contribution of the health districts to this service which was... which saw the financial and technical participation of Tubiteho, the support didn't continue as desired. That's what I wanted to tell you, and that sums it all up." (Program Director, Ministry of Health)

At the community level, participants in the northern region were skeptical about the actions undertaken that could contribute to the sustainability of the interventions. One participant spoke of the community work initiated by the project and the referral system, which he considered to be sustainable interventions. However, other comments by the same participant illustrate the difficulties of sustainability, particularly when referring to the ambulance.

"This is related to the referral and counter-referral system: each district has an ambulance, and you understand with me that if a single ambulance works in a district with two communes, to make these routes with, for example, 20 health facilities by making transfers, it may be depreciated or break down. You hear that it's not enough, so we had to be given other ambulances." (Provincial Medical Director, North)

A district chief medical officer from the North was also concerned about the continuity of interventions at the end of the project and expressed wishes for a transfusion station that in their view would help them sustain health gains. He also highlights a potential unintended consequence of not fully covering an entire region with capacity-strengthening activities, namely that community members will choose to travel long distances to visit a preferred health service site.

"Secondly, there is, I would say, a... movement of personnel. There are trained providers who leave to work elsewhere, even if it's in the same country.... There's a risk of people travelling long distances, saying that: It's better there ...than on the other side. So, if all the health centers were put on the same level, it would be much better.... We have an obligation to be able to continue these, these actions, but well, I could say that we're at an embryonic stage, especially in terms of... community activities.... I'm aware that we need to perpetuate, but it's not the time, it's not time for Tubiteho to close.... I'd say we're really at the embryonic stage, especially the community component." (District Medical Officer, North)

Results: Process evaluation

Research Question 5: What lessons learned can inform project management for the remainder of the project life and future potential follow-on designs?

When asked what lessons were learned from Tubiteho that can be used to inform future projects, participants mentioned a variety of factors that touch on project coordination, project design and implementation, community-based best practices, and system-level gaps and needs. Participants believed that taking these lessons into consideration is crucial to ensure that future projects are effective and sustainable. They also asserted that these lessons could influence better planning of health interventions that meet the needs of the Burundian population.

Working in consortium was a good practice.

Project staff praised the effort to work in consortium and believed that it enabled the sharing of expertise and experiences. Because each IP had their area of expertise, working collaboratively allowed the project to rely on individual partners' strengths to implement a project that addressed the needs of program beneficiaries. Regular coordination meetings within the consortium also enabled the project staff to discuss successes, reflect on challenges, and brainstorm potential solutions to any hurdles faced during the implementation phase. As such, project staff mentioned that for a similar health project to be successful, the approach of working in a consortium that also includes local organizations should continue.

> *"I've learned that ... there's strength in numbers. We still need to work as a consortium. If the members of the consortium are really aware of their role and put their heart and soul into it, we're not called upon, we're obliged to achieve results that a single organization can't claim to score." (PMC staff)*

Communication needs to be improved between donors, implementing partners, and stakeholders.

To improve program coordination, project staff reflected on the need to establish better and regular communication channels between the project donor, the IPs, and other stakeholders such as the Ministry of Health. According to project staff, improving this communication would help the project work towards creating activities that better reflect the country's priorities and integrate the perspectives of local leadership.

> *"And coordination with the teams, even with the donor's technical support team, which needs to be just as regular, because they too provided support. But at a certain point, we had the impression that there was a, not a distance, but it's as if there was no direct support.... It's as if we're in the same boat, but with a slight communication gap in relation to what needs to be done." (PSI staff)*

There should be better coordination with other health projects in Burundi.

When reflecting on what needs to improve for future projects to be successful, respondents mentioned that there should be better coordination between all health projects working in Burundi. Coordinating these projects would avoid duplications, ensure that programs reach different communities, and help programs work together to harmonize efforts and fill any gaps that one single program cannot address.

> *"The other organizations in the health sector ... the big problem I see at that level, sometimes, we're not in enough contact with them, in enough contact to harmonize everything we do, to coordinate everything we do.... I'm talking about other organizations. I'm not talking about our direct partners*

with whom we are in consortium." (Project staff)

Tubiteho needed more staff and district offices.

Pathfinder personnel believed that a project of Tubiteho's scope should have more staff and district offices. This would ensure that the project is closer to target participants and would improve the community-level coordination of planned activities. Further, having district offices in addition to provincial ones would have increased the project's reach and facilitated coordination with district health bureaus. For future health projects or should the Tubiteho project continue, there should be a budget planned to expand the number of offices and hire more technical personnel that could coordinate project implementation at the district levels.

"A large-scale project requires a lot of human resources so that the community and project staff can be close to the beneficiaries. So, maybe that could guide other future projects or the continuity of the project." (Project staff)

Health projects should budget for the remuneration of CHWs and volunteers.

Respondents mentioned that CHWs were key to the project's success, especially for community-based interventions such as the management of malaria at the community level. However, their workload and in some cases lack of remuneration often meant that they prioritized other health projects that offered them payment. It is important for them to be involved and trained in such health projects because they facilitate access to care within their respective villages. Therefore, for future considerations, projects involving CHWs and community volunteers should have a budget to motivate and compensate them for their work.

"Community health workers needed...here we call it motivation. This means payment, but it wasn't planned for. That's something to think about." (Project staff)

High health personnel turnover rate hinders project effectiveness.

Participants mentioned that there is a high turnover rate of health personnel, which impacts service delivery and the achievement of the project's objectives. Tubiteho relied heavily on these personnel, but their attrition made it difficult to implement activities effectively. In its implementation zone, Tubiteho often had to retrain health providers because those that had initially been trained ended up leaving for better opportunities. Thus, future health projects should consider how to implement interventions that target the stability of health personnel and the overall health system.

"The leadership must ensure that we have the right resources in the right place. It's all about staff stability in the health system. Because people who have acquired knowledge, if they leave, the whole system falls apart." (Project staff)

Shared responsibility with the implementing partners, government, provinces, and districts would enhance accountability.

Project staff mentioned that for the success of future projects, there needs to be clear, shared responsibilities and accountability mechanisms between all IPs (project implementer, government, provincial and district leadership, etc.). In addition to the project implementers, leadership in the implementation zones and different levels of partner ministries should also reflect on their responsibilities and achievements. This would promote ownership of activities and strengthen accountability.

"In Tubiteho's case, everything that didn't work was Tubiteho. You see what I mean? Even when you go

to the field, they say ... They [Tubiteho] didn't do it. Meaning what? And you [government and local leaders], what have you done? ... If it were possible, I think it's really something that could change ... I think it's very important, the shared responsibilities, because until now, we don't have a clear shared responsibility." (Project staff)

Central-level ministry should be at the forefront of project design and implementation.

For the project to be more successful, respondents mentioned that the central-level ministry (Ministry of Health) should have been at the forefront of the design and implementation of the project. Besides taking into consideration their fiscal priorities when planning Tubiteho activities, the Ministry should have been an active partner in the consortium and should have a central role in the implementation of various activities. According to the respondents, this would have facilitated project ownership and set forth a more effective sustainability plan.

"Support from the Ministry… I think that's something that wasn't really well handled at the project level. The Ministry… it's as if we tried to get closer to the operational level too much, but by putting the Ministry aside a bit ... I think it would have been better if the Ministry side, they were put forward." (PSI staff)

National coordination of all health activities in Burundi needs to be strengthened.

Participants also said that there should be stronger coordination mechanisms at the national level to ensure that health projects and activities are distinct and to avoid a duplication of efforts. Because this system is not in place and there is not much national level oversight, respondents mentioned that there was a tendency for each project to do what they think is right, regardless of what is already being implemented. Therefore, more coordination is required for improved allocation of resources.

"Among the challenges, really, the problems we have in our health system, I think, I think even in other areas, is coordination. We don't really have the strength; ... coordination [at the national level] remains weak." (Project staff)

Burundi should define a model of integration to follow.

Participants mentioned that the integrated approach was good practice because it takes advantage of limited resources and eases the burden of communities seeking multiple services. However, for integration to be more effective, it was suggested that Burundi should define a model of integration to follow (whether to integrate services at the institutional level or at the provider level) so that all integrated health projects are harmonized.

"Conceptually, I think there's a problem. And the problem, in my opinion, in Burundi, is that the country itself has not yet defined its integration model.... Some propose that integration should take place instead at the service-provision level.... That's one model and it could look like that. But I don't think Burundi has really made up its mind about all that yet." (PSI staff)

Working with and strengthening the capacity of local nongovernmental organizations is important.

Pathfinder staff appreciated the involvement of Dushirehamwe and CEPBU in the project and mentioned that continuous support and capacity strengthening should be provided to local NGOs to ensure that they can be recipients of and lead similar projects in the future. This was also believed to be in line with USAID's localization efforts, as involving NGOs in such projects will ensure the continuity of interventions even after

the project has ended. As such, all project staff interviewed asserted that similar large-scale health projects should work to improve the capacities of local NGOs to lead and manage the project.

> *"The empowerment of local NGOs and associations must always continue, so that they can properly assume what is expected of them as a viable institution tomorrow, and the day after tomorrow." (Project staff)*

Burundi's health information systems need to be improved and digitized.

Project staff appreciated that the project focused on training facilities and on how to analyze health data and use it for decision making. However, respondents mentioned there are gaps in the Health Management Information System (HMIS) that future health projects in Burundi need to address. The HMIS should be assessed to evaluate the type of data it collects and its completeness and accuracy. This would help set better priorities in terms of M&E trainings and will help produce data that is adequate for decision making. The system also needs to collect data on personnel turnover, equipment stocks, and more to gain a better picture of needs and to avoid duplication of efforts. In addition, the health information system needs to be digitalized to allow providers and decision makers to access health data in real time.

> *"For future projects… at least it's the digitization of the health system from the most peripheral level to the... because there's a big archiving problem at the health-facility level. There's also a big problem with tracking people who come into contact with the health system. And digitization of the health system, for example, the Open Clinic is used in hospitals and extended to all health centers. This can also help us make the right decisions. I think we also need to think about this digitalization." (Project staff)*

Community-based interventions are good practices that should be scaled up to other regions of Burundi.

Lastly, participants mentioned that the community aspect of the project was an innovative approach that should be scaled up to other regions of the country. Whether it be the community-based management of diseases such as malaria, community sensitizations, or community dialogues, project staff and IPs stress that community-focused interventions are important and should be part of future health projects. These are believed to make services more available and accessible and would increase their utilization.

> *"Another strategy is community dialogue, community dialogue on malaria control, community dialogue on the sexual and reproductive health of adolescents and young people, and community dialogue in schools and universities. These are also strategies... that have been appreciated by our beneficiaries." (Project staff)*

Overall, lessons learned to inform future program design and management include working collaboratively, community-based interventions, and considering various system-level needs and gaps. For future projects to be successful, they will need to leverage on identified strengths and address system-level and project-design gaps.

Research Question 6: Were the objectives, activities, and indicators used for Tubiteho implementation well defined (compared with USAID/Burundi and MOH strategies)?

Compliance with national guidelines and World Health Organization standards in the provision of health services

The objectives, activities, and indicators for Tubiteho implementation were well defined and aligned with USAID/Burundi and MOH strategies. This alignment ensured coherence with national and international standards, enabling effective M&E consistent with the strategic goals of both organizations. Interviewees reported that the Tubiteho project provided regular training and national guidelines, leading to increased adherence to WHO standards. The project covered areas such as FP, immunization, malaria, and GBV management. Testimonials indicated improved provider compliance, reducing misdiagnosis and improper prescribing.

Data collected in the northern region indicate that guidelines were available in health centers and that protocols were visible in providers' offices, showing a willingness to comply. Another provider notes that the Tubiteho-supplied protocols were in use and positively impacted disease management. However, a general practitioner mentions that while protocols are posted, there is no training provided for their use.

> *"Yes, this project has helped. As a matter of fact, I would have already answered your question about training. Even if I wasn't here, there's still information I've already asked for. When I arrived here, I found some protocols with badges from the Twiteho Amagara project. I can see them even though they were acquired before I arrived. They're protocols for the management of illnesses that are very common in the region. They're posted in the offices of healthcare providers; I can attest to that. Even if they were given to me before I came to this hospital, I see them where they're posted." (Gynaeco-Obstetrics Doctor, North)*

Interviewees report that the Tubiteho project has provided regular training and national guidelines. A district medical director in the South confirms that protocols are implemented in accordance with WHO guidelines. The project offers ongoing training for providers in areas such as FP, vaccination, malaria management, and GBV, ensuring that these national clinical guidelines are accessible in health facilities. This training and the availability of protocols have improved compliance with national and WHO guidelines, reducing diagnostic and prescription errors. However, the frequent turnover of trained staff necessitates continuous training.

> *"There has been training on the new malaria management guidelines, but that was three years ago. There's another training session on IPTp, guidelines for combating malaria in pregnant women. This IPTp training took place a month ago. But on the management of malaria, that was a long time ago. With staff mobility, this is becoming a problem. So many of the people already trained have been transferred. (District Hospital Medical Director, South)*

According to the PNILP staff, the project assisted in drafting new malaria-control guidelines. In collaboration with UNICEF, the program evaluated the intermittent preventive treatment strategy during pregnancy and provided data for updating guidelines to align with WHO best practices. The director highlighted the extension of malaria management to the community level as evidence of compliance with WHO recommendations for strengthening primary health services.

"As far as we're concerned, he has supported us in the implementation of normative documents, guides, and guidelines. One example is the updated guidelines for intermittent preventive treatment of malaria during pregnancy. He also participated in the drafting of new guidelines for the fight against malaria, which have just been prepared. When I say participation, I mean financial and technical participation." (Program Director, Ministry of Health)

According to the PSI implementing partner, the Tubiteho project has implemented district coaching, formative supervision, and refresher training to ensure health providers comply with national and WHO guidelines. As part of this effort, each health center has had at least two care providers trained in the recommended malaria treatment protocols established by WHO and the Ministry of Health.

"We've done quite a few things. There's one training course that actually follows the national malaria guidelines. Today, at each health center, providers have been trained, at least two by the CDS or health facility where now they follow the national malaria treatment guidelines." (CEPBU member, Health Center C)

"Interviewer: *What contribution has the project made to ensuring that malaria management services are provided in accordance with national guidelines?"*

"Interviewee: *That's been done, mainly through district coaching and also formative supervision at health-facility level, but also from time to time even organizing refresher training, whether for laboratory assistants, whether for the health providers themselves, but also a little for community health workers." (PSI staff)*

Tubiteho contributed to the development and implementation of the SRMNIA (*santé reproductive, maternelle, néonatale, infantile et des adolescents;* reproductive, maternal, newborn, child, and adolescent health) protocol. As a project staff member explained:

"So, we've also provided technical support. We've provided technical support for the development of certain protocols, for example, the protocol for... More like the Family Planning 2030 commitments. So, the Tubiteho project contributed to the development and implementation of this. The development of the SRMNIA protocol. This is a national protocol for health; reproduction; [reproductive health]; maternal, neonatal and child health; and adolescents. It's a national protocol that is actively used by the PNSR, which encompasses almost all of the Ministry's programs. We also contributed to the updating and development of this and other modules... So, the offer of subcutaneous antiretroviral subcutaneous depot injections at community level. This time, we've added self-testing as part of self-care." (Project staff)

The project's staff notes that Tubiteho also offered training on voluntary contraceptive surgery. In response to a question about the support provided to the Ministry of Health, the FP manager stated:

"I'm talking about FP. The Tubiteho project contributed to the development of a training protocol on VCC—VCC is voluntary contraceptive surgery, which means tubal ligation and vasectomy. The module is here. The trainer's module, the participants' module. All these modules. They were set up by the Tubiteho project." (FP Manager)

Enhanced early disease detection, proper management, and referral

The project successfully improved early diagnosis and community-based care by training CHWs and health providers in new disease management guidelines. CHWs can now diagnose and manage certain diseases,

with referral mechanisms in place for complex cases. Interviewees raised concerns about some providers' lack of empathy and rapport with patients, which can harm trust, treatment adherence, and patient satisfaction. Addressing this requires integrating emotional intelligence and communication skills into training programs to foster a more supportive and holistic healthcare environment.

In the northern region, community-level diagnosis of malaria and malnutrition, management of malaria in children under 5 years along with referral of severe malaria cases and childbirth and GBV incidents are reported. Respondents noted that CHWs are consistently available and proactive in referring and accompanying women during childbirth at CDSs and in cases of malnourished children.

> "Participant: *If it's time to give birth, community health workers mobilize quickly to take the person who wants to give birth. For someone who wants to give birth, they mobilize very quickly. That's something they take to heart. They're really very efficient and quick to act. If the woman is in labor, they ask her to get ready quickly to go to the health center. [...]*
>
> *The community health workers look after the children. If someone has a malnourished child, they require them to take [the child] to the health center to receive cookies to grow up like the others." (Women's FGD, Health Center A)*

Interviewees in the South reported that health providers have been trained in new disease management guidelines. The project has also trained CHWs to recognize early symptoms of diseases like malaria, TB, and GBV, encouraging prompt medical consultation. CHWs have been equipped to detect and manage malnutrition, and referral systems have been established to direct patients to appropriate health facilities. These efforts emphasize the importance of malaria case management, community-based disease management, collaboration with health facilities, and effective malnutrition management.

> *"Project staff have trained the CHWs, so now they know how to diagnose certain illnesses. [...] Using the MUAC [mid-upper arm circumference], they can identify a child who is severely or acutely malnourished; and if they test a child and find that he or she is severely malnourished, he or she is transferred directly to the CDS." (TPS, Health Center D)*

Tubiteho collaborates with various organizations, including WHO, UNICEF, and the United Nations Population Fund, to provide clinical mentoring for EmONC, contributing to the early diagnosis of obstetric and neonatal complications. Participants believe that the Tubiteho project has enhanced malaria diagnosis and management by extending community-based care and implementing effective communication strategies for malaria prevention.

> *"But also, in relation to communication for social and behavioral change, the Tubiteho project has always contributed to the proper use of malaria-control services. In all the provinces we've mentioned, including Bururi and Rumonge, we've held communication sessions to encourage social and behavioral change in favor of the fight against malaria. You'll also find that it has supported the program." (Program Director, Ministry of Health)*

According to a PSI representative, the project has strategically contributed to early disease diagnosis by establishing diagnostic and management capabilities at the community level. He states:

> *"So, early diagnosis, I think, is one of the things I could personally boast about, that is above all having brought diagnosis and care to the community level. I remain convinced as a doctor because, 'nsigaye ndandaza akarimi' (his line of work involves more talking). In the past, I was a doctor, and I worked in*

health facilities. And I've seen in my practice, sometimes we tell people to go to the health center, go to the hospital, and we think it's as simple as that. But going to the health center sometimes involves costs that people in the community sometimes can't afford. So, if you bring services closer to the community, there's added value in bringing the service closer to the community." (PSI staff)

Definition of objectives and indicators

The objectives align with USAID's strategies, which are in turn consistent with the needs of the Ministry of Health and AIDS Control. According to a former USAID project AOR who initiated the project, discussions were held with the Ministry of Health, especially within the relevant programs, to identify needs and set priorities.

"We reviewed the DHS indicators that showed a higher prevalence of malaria in the North. Additionally, USAID works in the northern provinces. The previous project was working in those provinces, and the HIV programs were in those provinces. Malaria prevalence is the highest in those northern provinces.

And we look at the maternal and childcare and FP indicators, and those indicators are the lowest in the social South and southern provinces. So, we wanted an integrated approach. But different geographic areas have different issues related to different indicators. So, we still keep them integrated. But we decided to make a predominant malaria focus in the northern provinces and predominant maternal and child care and FP in the southern provinces to fit the needs of different regions. This is like the principal source or the sources of data, like, as I said, the integrated… there was an integrated mechanism that was ongoing. So, we looked at program programmatic data from that mechanism also to inform the design.

We also did an RFI, a request for information, and received feedback from different prospective applicants. In addition to that, we had conversations with different programs at the Ministry of Health, not like beneficiaries at the communities, but the health manager is in charge of those different programs, to understand their visions, their needs, and their perspective on the follow-on, of the ongoing mechanism that was in that place." (USAID former AOR for Tubiteho).

In the northern region, the project's objectives were developed without consultation. However, one of the district medical officers appreciates its support for community interventions and believes it has effectively addressed local challenges.

"So, I'd first like to salute the interventions of the project since at the district level, we should first make major efforts at the community level, yes at the community level. Sometimes we can't do it, given the means. I'd say that the Tubiteho project has enabled us to activate the community level, which hasn't yet reached the desired point. But with the Tubiteho project, we can really see that community interventions are being activated, and this enables us to manage our interventions at the health-facility level since there are cases that should be queuing at health-facility level, but which for the moment are being managed at community level. There is some information that we wouldn't be able to access if the community level wasn't active. But for the moment, we're collecting data in real time at the community level, mainly through these Tubiteho project interventions. In particular, if malaria is the main reason for consultation in our district, it allows us to find out what the situation is at community level through these projects." (District Medical Officer, North)

Further, the provincial health director in the North notes that some priorities were overlooked. They

believed that these issues—particularly related to training, the need for qualified personnel, and other requirements—could have been addressed with proper consultation.

> *"For example, a province needs qualified service providers because more than 70 percent of service providers in the province are on contract, i.e., around 30 percent are paid by the State. This means that in many of our health facilities, there is a shortage of qualified staff. This is the province's priority, and if it hasn't been planned for in the project, we can say that it's a problem.*
>
> *"This is related to the referral and counter-referral system: each district has an ambulance, and you understand with me that if a single ambulance works in a district with two communes, to make these routes with, for example, 20 health facilities by making transfers, it may be depreciated or break down. You hear that it's not enough, so we had to be given other ambulances. In addition, there's the issue of funding for the health system, which is sometimes lacking, with free care, delays in CAM (Credit d'Aide Médicale;* Medical Aid Credit) *payments, delays in FDP (Fonds de Développement des Prestations;* Funds for Development of Services) *payments. So we find that funding for the health system is insufficient and we can't make progress in terms of the health system, and we find that this is a challenge or a priority at the provincial level, but it hasn't been designed at the project level, so it's a problem.*
>
> *There are some places where there is a shortage of water in the health facilities, but it's not all the health facilities. But you understand, that if there's a health facility that doesn't have water, it's a major problem, but as it's not a project priority it's difficult.*
>
> *I'd say that all the objectives they've set for the Tubiteho project are working well, except if other projects could intervene in this or that area, or if there's a review of the project's activities, or if there's joint planning so that we can tell them the province's priorities so that they can be achieved, because priorities come up from time to time because they can find the solution to certain problems, and others remain." (Provincial Medical Director, North).*

A PNILP staff member, who has experience with USAID-funded projects, endorses this approach.

> *"Thank you, so, I have to admit that when the project was set up, I wasn't here; but still, in the spirit of continuity of responsibility of power, I have to clarify some aspects. As the Tubiteho project is financed by USAID, USAID has its own modus operandi when it comes to defining projects. It has what they call MOPs (Malaria Operational Plans), which are annual operational plans that are revised every year.*
>
> *But, even before the annual review, there's what's called, I can't quite remember, a plan that may be three years or four years ... long term. To plan this, USAID approaches the program, we plan together, we define the priorities by analyzing our strategic plans, already identifying the gaps by strategic axis and then USAID defines a project based on the programmatic gaps identified together with the program. As you can see, the program participates directly or indirectly in the development of the project.*
>
> *USAID then submits a call for applications. There are various types of bidders. So, the project is set up this way because the people, the ones who are going to win, they align themselves with the project priorities that have been defined by USAID.*
>
> *You'll find that Tubiteho [is] in everything it does, it fits into the program priorities. There isn't an intervention Tubiteho does that doesn't fit into the program's strategic plan. I really think that's good." (Program Director, Ministry of Health)*

For one of the district medical officers, the fact that the project is aligned with the priorities of the Ministry of Health is proof that the project is aligned with their priorities.

> *"The objectives of the Tubiteho project align very well with our objectives because they align with the objectives or guidelines of the Ministry of Health. In the Ministry of Health, the main focus is on maternal and child health. This means that if a project supports the maternal and child health sector, it normally makes a significant contribution to current national policy. That's why we really appreciate this project." (District Medical Officer, North)*

In summary, national and WHO standards were disseminated in both intervention regions, but training on their use was not reported in the North. The project did not introduce new guidelines but collaborated with stakeholders to update existing ones. It contributed to updating the guidelines, providing training on their use, and supervising their implementation by providers, alongside other partners.

Research Question 7: Has Tubiteho collected adequate monitoring and evaluation data on routine performance indicators to capture project performance? Why or why not?

In this analysis, "adequacy" is assessed along several dimensions. First, was the project's set of routine performance indicators appropriate for assessing project performance? Second, were the data sources available at a frequency that allowed for adjustments to Tubiteho's approach? Third, what was done to ensure the quality of the monitoring data? Lastly, were the data used for decision making (an indicator of trust in the data and the usefulness of the data)?

Indicator selection

Tubiteho reported on a set of 63 performance indicators. According to the project's M&E officer, the project's indicators were those of the Ministry of Health; the project only provided support for data collection and analysis, in collaboration with those responsible for the national health information system. He noted that before the project was implemented, community indicators were not collected. The project helped set up the community information system, and these indicators are now integrated into the national data collection system. He also adds that the number of indicators used in monitoring is a challenge, as they are numerous.

> *"If you look at all the project indicators, they were indicators that are integrated into the national system already, except for some indicators, but as part of the processes, until last year, we were able to integrate these indicators into the national system. Now, all Tubiteho indicators are integrated into the national health information system. [...] The first challenge was the number of indicators Pathfinder negotiated. It negotiated a lot of indicators. In other words, in Tubiteho's performance framework, there are mandatory USAID indicators.*
>
> *There are also other program management indicators, i.e., indicators that are not mandatory with regard to USAID, but they are indicators that will show the project's progress, in terms of service quality and availability. As you can see, there were a lot of indicators. The more indicators you collect, the more difficult it is to obtain quality data. As you can see, that was a real challenge." (Project staff)*

Overall, the project staff who were interviewed felt that they had adequate data to manage project activities. If anything, the sentiment was that the project had too many indicators.

Data sources

Indicator data came from a variety of sources collected at a range of intervals. Table 4 shows the numbers of indicators associated with each data source, categorized by the aspect of Tubiteho they measure (goal,[4] purpose,[5] IR).

The majority (6/7) of the indicators assessing progress toward Tubiteho's goal and purpose were calculated at pre/post only; there was no midpoint assessment. As a result, Tubiteho was limited in its ability to make evidence-informed mid-course correction in its approach.

[4] Goal: Health of Burundians, especially of women, children and infants improved
[5] Purpose: Increased use of quality health systems

Lastly, the number of indicators associated with each IR was not equivalent. The M&E efforts were skewed toward measuring IR 1 (access to services). Progress toward IR 1 was measured using 32 indicators, 24 of which were reported on a quarterly basis. There were 13 indicators associated with IR 2 (health behavior change), 5 of which were only reported pre- and post-implementation. The implication of this is that the project only had eight indicators with which to assess IR 2 on a continuous basis. IR 3 (health system strengthening) had only 11 indicators, although 10 of these were reported on at least an annual basis.

When asked what additional data would have been useful, project staff listed data related to IR 2: community-level health data and SGBV, and IR 3: facility staff transfers (to understand the skills and training needs on a continuous basis) and comprehensive equipment data.

Table 4. Numbers for Tubiteho's indicators by data source and aspect measured

Frequency	Data Source	Goal	Purpose	IR 1	IR 2	IR 3	Total
Pre/Post	• DHS • Household survey	5	1	0	5	1	**12**
Annually	• Facility assessment • Government data • End-use verification survey	0	0	8	0	5	**13**
Quarterly	• DHIS2 • Government data • Implementation data • Facility assessment	0	1	24	8	5	**38**
Total		**5**	**2**	**32**	**13**	**11**	**63**

Data quality assurance

Project staff expressed the belief that the large number of monitoring indicators compromised data quality. In an effort to improve data quality, Tubiteho initiated capacity-strengthening activities for community-level site staff in the collection of community indicators, and subsequently organized supervisory and coaching visits. Coaching activities for CHWs in data analysis and use were also done. At the health-facility level, the project's contribution was essentially to encourage staff to use the national data collection system via the DHIS2 platform.

> *"But at the community level, […] it was like the beginning and there were no partners in these provinces that we took on; there were no partners in the community system. And what we did was to train them. First of all, we trained the staff in the community system, and then we focused on visits and coaching. And then we moved on to data verification, data auditing, and so on, right up to the present day. I think it's a process we've gone through from the outset, preparing this project at community level.*
>
> *But at the facility level, at health-center level, what we really did was to initiate people to the use of DHS2 platforms, which is a national platform. [...] In other words, people at the operational level had to use this system in terms of data entry, data analysis, and data validation. That's the way we've done it so far." (Project staff)*

Project staff also reported that training courses in M&E had been organized for the project's local partner organizations, and focal points have been set up with partner organizations to help them monitor their

data. A data manager was appointed to support sub-recipients in collecting and monitoring their data. Tools were provided to help sub-recipients track and verify their data. CEPBU and Dushirehamwe were involved in the process, but scheduled meetings are not regular due to the high workload. Online meetings are sometimes held, although participation is not always optimal.

> *"In terms of monitoring and evaluation, we've organized training sessions on monitoring and evaluation. And we also have what we call focal points... focal points followed by two organizations to work together. You see? And CEPBU and Dushirehamwe, they're involved... even, we even have a group." (Project staff)*

Data for decision making

Respondents reported being involved in the evaluation of the Tubiteho project, notably through feedback meetings, exchanges with project managers, giving feedback to the provincial or central level, and joint supervision. The project also supported data evaluation meetings, which were designed to provide quality data for evidence-based decision making.

Ministry of Health staff spoke about Tubiteho's efforts to strengthen providers' capacity to analyze and use data.

> *"So, as far as these provinces are concerned, for us, the activities that have been carried out are the strengthening of service providers in the analysis and use of health information within these intervention provinces. [...] There were organized activities such as data quality audits relating in particular to data triangulation as part of the fight against malaria. (Asking ourselves): Are the data supplied to the health facilities real data? We did that together, and they would come here to the office, and we would contact each other and plan together. In addition to that, our management organizes partner coordination workshops." (PNILP Director)*

In the northern region, informants reported that the project supported health facilities in the use of the national health information system, field supervision with district staff, and quarterly data analysis meetings. One of the medical directors in the northern Provincial Health Offices expressed regret, however, that they were not involved in the evaluation of project activities and that the project did not give them regular reports on their activities.

> *"We haven't done the results because we've never done the midterm evaluation of the results of the activities that have been done by the Tubiteho project, and I can say that it's a challenge because if you do a project and you do it jointly, there will be an evaluation to take up the challenges and then those that have worked well, they need to be supported. The reports are very difficult to get, but it's not just them (Tubiteho); it's the same thing with other NGOs working in our province. What's more, we're asked for these reports by the Planning Department of the Ministry of Public Health, and they ask us for them on a monthly basis because we assume that these are activities that have been jointly planned and that we have to submit to our Ministry. I'm not suggesting that it's only the Tubiteho project, but in the majority of organizations operating in the province, it's a problem to report on activities." (Provincial Health Office Medical Director, North)*

Informants from the southern region reported that the project supported field supervision missions and quarterly meetings to evaluate data, particularly on indicators relevant to project areas.

> *"Tubiteho and we have meetings, if you like. And then there's what's called CPSD (Cadre de*

Partenariat pour la Santé et le Développement Provincial; Partnership Framework for Provincial Health and Development), where every quarter the Tubiteho project gives a report to the BPS (Provincial Health Office). At the district level, we give the BPS a report on what the project has achieved in our area. There is also a meeting to evaluate achievements. You understand that we get the report on their achievements. [...] They give them to us. And when there are doubts about what we've achieved, we organize an analysis meeting to check what we've done. They also analyze our data at the same time as we do. There are times when we notice there's a problem. We get together to see how we (the district) can improve." (Chief Medical Officer, South)

"Generally speaking, after our field visits, we often make restitutions of our visits in the field. What's more, these feedback sessions are supported by the Tubiteho project. I can really testify to that. From there, when I see that something's not right, I can take appropriate decisions for that area, or think about organizing moralization sessions to give standard advice to improve the quality of services. These monitoring-evaluation missions really do exist." (Provincial Office Medical Director, South)

In addition to meetings to evaluate supervision and analyze data, the provincial health department discussed organizing meetings with provincial health partners to assess the contribution of each partner.

"In principle, we have what's called a provincial CPSD (Cadre de Partenariat pour la Santé et le Développement Provincial; Partnership Framework for Provincial Health and Development), There are also national CPSDs. So, this CPSD is a framework for exchanging information on all partner activities carried out during the quarter preceding the meeting. The meeting is attended by all partners present in the province. It thus becomes a common opportunity to evaluate the activities carried out by all partners during the quarter. Within this framework of exchanges, if there are objectives that have not been achieved, we give advice to those concerned, based on the results obtained as well as the checklist, and finally, we formulate recommendations." (Provincial Health Office Director, South)

Finally, informants in the southern region stated that Tubiteho also provided reports on its activities to the Provincial Health Office, even if irregularities were observed.

"Reports are submitted to the health province for the BPS, which in turn reports to the Ministry. There are cases where they haven't submitted reports, probably because of lack of time, but they still report on their activities. I wouldn't say they're 100 percent committed, but they are committed." (Provincial Office Medical Director, South)

Despite these efforts, informants cited the lack of a culture of data use as an ongoing challenge in promoting evidence-informed decision making.

"The final challenge. In general, if you look at the level, central level all the way down to the operational level. It's really the data culture, in general. Because we work in a system where the culture of data really isn't yet ... because most doctors, they're still, they're still clinicians, they're not really rooted in public health yet. You know, in public health, data counts. In other words, you have to look behind the numbers. Because data, more data, data can also show quality of service. And data also help you plan in terms of inputs. You'll find that really at the central level, i.e., at the top level, right down to the operational level, this culture really hasn't yet entered our service providers" (Project staff).

Research Question 8: How has project integration improved and/or hindered the achievement of objectives in Family Planning (FP), Maternal and Child Health (MCH), Malaria, Nutrition, and Gender-Based Violence (GBV)?

This section presents the positive and negative impacts on project performance. Barriers to project integration are also discussed.

Positive impacts of integration on project performance

The main benefits of integrating the Tubiteho project, according to informants, are the ways in which the integration of services provides comprehensive care for pregnant women and children, including FP, prenatal care, and immunization, thereby reducing complications and ensuring safer births. In addition, patients receive multiple types of care in a single visit, reducing travel and waiting time. For providers, this simplifies appointment management and maximizes the efficiency of human resources.

> *"The first advantage is that the quality of service is improved. So, services are given just as much. So, there's no loss of time for the customer. There's no loss of time for the service provider. He offers at least three services at the same time in the same place, without having to move around too much" (Project staff).*
>
> *"The advantages are numerous. First, for the community, integration saves time. Integration saves time because many services are offered for one, just one visit. For a single visit, the woman receives the ANC, receives the [long-lasting insecticidal net], can go for [a] consultation for her child, her 2-year-old, 3-year-old, 4-year-old child; so, it saves time. Integration saves time, really, for the beneficiary! It also saves time for the provider because if the beneficiary has to visit the ANC providers, the consultation provider… it saves time for several services in a single visit." (Project staff)*

Informants observed that a holistic approach strengthens patients' confidence in the health system, encouraging them to follow medical recommendations.

> *"Normally if the integration is carried out well, there's an increase in confidence with regard to the staff. If you go to a health facility, if the provider doesn't give you enough time, there's a real gain in confidence compared to the customers. And then, in relation to beneficiaries, the beneficiary receives several packages at the same time, in the same place with one or other provider; but above all what's important is that the patient or client comes home with many services on the same day and at the same time. It's a real confidence booster." (Project staff)*

With integration, providers acquire a wider range of skills, improving the quality of care they provide, with more accurate diagnoses, appropriate treatments, and careful monitoring of patients' health.

> *"In the integration of services, providers increase their skills, augment their skills, or are obliged to increase their skills to be able to offer several additional services…which had motivated the visit of the beneficiary." (Project staff)*

Integration also avoids duplication and overlap in care provision, maximizing investment in the health sector and ensuring better coverage of populations. By the same token, integrating services raises community awareness and changes harmful behaviors, for example by addressing FP and GBV in the same context.

> *"So, integration will enable us or the project, you know, to produce change; [...] integrated interventions make it easy and quick to produce change." (Project staff)*

According to the technical staff, the number of services offered by the health facility can be increased while reducing dropout cases, which enables it to gain financially thanks to performance-based financing. Lastly, the integration of services can help reduce misconceptions and risk behaviors by educating patients in a holistic way.

Negative impacts of integration on project performance

Informants expressed that, due to workforce shortages, the transition to a more integrated model of service delivery may further overburden staff. In some cases, staff were reluctant to integrate health services, leading to resistance and inefficiency during implementation, which could negatively impact performance indicators. Further, data collection and reporting tools have not been updated, leading to more inefficiency and confusion for staff.

> *"But our tools are not really prepared for this integration of health. Health staff are already overloaded and are reluctant to integrate new concepts because of the extra workload involved. Health centers don't have enough staff. [...] They already have a lot of activities, and if you ask them to integrate new concepts, they're a bit reluctant because it's an additional workload for them." (Project staff)*
>
> *"Because if there was a national model, if for example the national model says it's a one-stop center, someone comes and where they've been received, they're offered all the services that are, that are part of this package. [...] They're used to doing things in one way and you come and tell them ah, we need to change and in addition to what you tell them, it can lead to demands in terms of how to organize the work. And even that can take a bit longer for the service provider." (PSI staff)*

Informants also mentioned that integration of services within a single visit could lengthen wait times at the facility, as individual patients spent more time with their provider. Lastly, project staff explained that an integrated approach was more labor-intensive for the project. The high levels of staff turnover meant that there was a constant need for training. Further, training staff in the provision of integrated services itself was more time-consuming, difficult, and resource-intensive than a more disease-centered approach.

Barriers to integration

Project staff expressed that there was a need for national guidelines and a clear model to support the integration of health services to ensure effective coordination and understanding of integrated projects. The lack of a clear model inhibits collaboration among organizations working in health, as there has not been a common understanding of how and why to integrate their approaches.

> *"For example, when I go to CDS Butare with a GBV survivor and say that I'm a member of Dushirehamwe working in the Tubiteho project, I'm told that this is the first time we've heard that. There's been a lack of collaboration and I'm asking for frank collaboration next time. If he's working on FP and I'm working on GBV, they're complementary. [...] I'm not denying that we were complementary, but we never met anywhere in the field. I'm going to say that during training sessions, we should meet in the same room so that we can discuss our common objectives and our different tasks. I'm not saying that we didn't work together fully, but what was lacking was this closeness between the participants, between the project organizers and all those involved in the project. But, generally speaking, we work with CHWs and mamans-lumière [Light Mothers]." (Dushirehamwe member, North)*

Discussion

For each research question, the findings and implications for future projects are summarized below.

To what extent did Tubiteho achieve its objectives for the three intermediate results and nine sub-results?

Access

The Tubiteho project improved access to quality health services through various activities that targeted an improvement in the quality of services offered at health facilities and an increase in the demand and utilization of health services. In all five domains, CHWs and health providers received trainings on areas such as emergency maternal, obstetric, and newborn care; the administration of modern contraceptives including the Sayana Press; community-based management of malaria; and case management for GBV, among others. Within the domains of nutrition and FP, capacity strengthening for health providers was supplemented with community sensitization on available FP and GBV services and the importance of reporting cases of GBV through appropriate channels.

In addition to activities to improve the quality of services, the project also made efforts to integrate the services offered to ensure that beneficiaries receive a comprehensive package of care; for instance, malaria and FP services were integrated into MCH services. Lastly, Tubiteho also provided medical equipment such as delivery tables and vacuum aspirators to health centers and provided means to transport contraceptives from Burundi's central drug purchasing agency's warehouse to its implementation zones. Although project staff, IPs, and targeted project participants all affirm that they saw an increase in the utilization of health services as a result of Tubiteho interventions, factors such as a frequent medication stockouts, high turnover of medical personnel, and religious and cultural norms impacted the project's progress in achieving its objectives. In spite of these challenges, Tubiteho's ability to be flexible and work within the limitations of the given context contributed to its success as a service delivery project. However, without a sustainability plan in place, it remains unclear how these activities, especially trainings, will be maintained without Tubiteho's assistance.

Health behaviors

The Tubiteho project utilized a combination of mass media, group education, and interpersonal communication strategies to raise awareness and increase demand for health services in Burundi. This multifaceted approach led to perceived significant improvements in health-seeking behaviors, with data from stakeholders indicating a notable rise in service utilization, particularly in maternal health and early consultations for illness. The project also contributed to shifting gender norms that support the reduction of GBV and promoting collaborative decision making in health. CHWs played a pivotal role in these outcomes, both by encouraging appropriate medical consultations and by increasing trust within the community. However, challenges such as transportation costs, self-medication, and persistent reliance on traditional healers continue to hinder progress. Additionally, while there has been a reduction in GBV and a shift towards more equitable health decision making, some resistance to these changes remains, particularly in fully addressing reproductive health service uptake and judicial recourse for GBV survivors.

Health system strengthening

The majority of Tubiteho's activities were designed to support the health system through training staff, providing equipment, funding transportation, etc. We did not find evidence that systems and sustainable funding mechanisms were put in place to ensure that staff were continuously trained, that equipment would be continuously provided and maintained, and that transportation would remain available. Tubiteho's main contributions to strengthening the health system are the development of protocols and guidelines, strengthening the client management and referral systems, and laying groundwork for a system of supportive supervision.

What factors inhibited or facilitated Tubiteho's success in achieving its objectives?

The Tubiteho project succeeded due to its strong foundation on USAID's prior work (especially in the northern region), continued funding, and effective collaboration with the Ministry of Health and local partners. The integration of Tubiteho's activities into the Ministry's action plans and the use of innovative communication techniques, such as the Sabido methodology, were key in promoting positive health behaviors and achieving the project's objectives.

The project challenges included fuel shortages, high staff turnover, equipment shortages, supply stockouts, and disruptions from the COVID-19 pandemic. Cultural barriers, slow workplan approvals, budget constraints, and limited local engagement further hindered its success. Additionally, issues with coordination and an overwhelming number of indicators complicated project implementation. Overall, while the Tubiteho project made major progress, these challenges highlighted the need for more robust planning, better resource allocation, and enhanced local participation to ensure sustainability.

There were many health projects that operated concurrently in Burundi during Tubiteho. These projects, particularly those that operated at the national level or within Tubiteho-supported provinces, may have contributed to Tubiteho's success in reaching its quantitative targets. In some cases, Tubiteho coordinated their efforts with these projects. This was particularly true for the other projects that USAID funded.

How have local perspectives been integrated into Tubiteho's planning and implementation, and how do they view the project?

The Tubiteho project made concerted efforts to integrate local perspectives into its planning and implementation processes, with a focus on tailoring interventions to the specific needs and contexts of different regions. The project employed a participatory approach, involving local stakeholders such as CHWs, health providers, and ministry programs in the planning and decision-making processes. This approach included data collection at the community level, coordination meetings, and community dialogues to ensure interventions addressed locally identified health challenges. However, the effectiveness of this approach varied by region, with some respondents in the North expressing concerns about limited involvement in decision making and the project's inflexibility in planning. While many community members and health providers acknowledged the project's responsiveness to local needs, gaps in communication and challenges in joint planning were also noted, highlighting areas for improvement in the project's collaboration with local partners.

What are the plans and prognosis for sustainability after the project ends?

The Tubiteho project faced challenges in establishing a clear and actionable sustainability plan, despite the initial intention to ensure the longevity of its interventions through innovation, capacity strengthening, and integration into national guidelines. While project staff and Ministry of Health personnel acknowledged the potential for sustaining certain gains—such as strengthened provider skills, improved data management practices, and the continued use of medical equipment—the absence of a comprehensive sustainability strategy raises concerns. The project's reliance on ongoing advocacy to integrate successful practices into national guidelines and the lack of explicit partnerships with other organizations or donors further complicate the prospects for sustainability. Additionally, issues such as rapid staff turnover, limited resources for equipment maintenance, and inadequate ownership of project activities at the district level threaten the continuity of Tubiteho's achievements. Participants expressed mixed views on the project's sustainability, with some highlighting structural problems, such as the inadequacy of a single ambulance per district and the uneven implementation of capacity-strengthening activities, which could lead to disparities in service quality and access.

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

Several lessons from Tubiteho point towards the need for future projects to address system-level challenges to ensure the continuity and success of activities. For a project similar to Tubiteho to be successful, the central-level ministry should be at the forefront of project design and implementation of the project. This would ensure that activities conducted align with ministry priorities, promote ownership of activities at the district and national levels, ensure the continuity of activities after project end, and would also improve accountability of all involved stakeholders. At the national level, coordination of all health activities should be strengthened to avoid duplication and to encourage collaboration among projects that address similar domains. Further, while Tubiteho has tried to improve the use of data for decision making, the current health information system needs to be digitalized and expanded on to include information on personnel movement and equipment availability; such a change would enable access to real-time data to facilitate decision making and improve resource allocation. With these lessons in mind, future projects can leverage on the strengths of Tubiteho—notably, working in consortium and community-based approaches—to develop projects that address community needs and those of the health system in Burundi.

For the continuation of this project and future projects, there is a need to improve communication between the donors, IPs, and project stakeholders. In the case of Tubiteho, better communication would facilitate a clear understanding of project vision and objectives, promote a sense of shared responsibility and accountability for project outcomes, and improve the coordination of various project activities. Donors, implementers, and other partners, hence, would be seen as integral parts of a single team working towards a common goal, which would address silos between the donor and project implementers. In turn, this would promote harmony at different administrative levels and enable a more effective and efficient execution of the project.

Were the objectives, activities and indicators used for Tubiteho implementation well defined (compared with USAID/Burundi and MOH strategies)?

The project's activities and objectives were developed to align with the strategic goals of both

USAID/Burundi and the Ministry of Health. The project contributed significantly to enhancing health delivery in Burundi by promoting adherence to national and WHO standards, through regular training and the dissemination of national guidelines. It played a key role in updating national health protocols, particularly for malaria management, and making these guidelines available at the community level. This approach aligned with WHO recommendations for strengthening primary health services and was instrumental in improving early disease detection and management. Notably, health centers in the northern region visibly displayed these protocols, indicating a commitment to compliance. However, challenges remain, particularly in sustaining training efforts amidst frequent staff turnovers. As highlighted in the key informant participant interviews, there were gaps in training, particularly in the northern region, which was overlooked due to a lack of consultation. The lack of consultation in this area suggests that while the project made significant progress, there is a need for more inclusive planning and continuous support to ensure long-term success and sustainability.

Has Tubiteho collected adequate monitoring and evaluation data on routine performance indicators to capture project performance? Why or why not?

The indicators that Tubiteho tracked were sufficient for the project's day-to-day management. However, the project lacked a way to assess impact on an ongoing basis; many of the data sources used were available intermittently. Had the evaluation been planned from the beginning of the project, and especially if a midpoint evaluation had been conducted, USAID and the IPs would have been able to make evidence-informed course corrections throughout. There was evidence that data were used for decision making, although informants noted that there was work to be done to institutionalize this practice. Tubiteho worked on improving data quality, mainly through training and supervision. However, the large number of indicators and nascent state of data quality assurance in Burundi mean that it is likely that data quality issues persist. The health system could benefit from periodic data quality assessments.

How has project integration improved and/or hindered the achievement of objectives in Family Planning (FP), Maternal and Child Health (MCH), Malaria, Nutrition, and Gender-Based Violence (GBV)?

Service integration ensured that patients received more of the services and health education that they needed, regardless of their initial reason for the visit. This decreased their overall travel and wait times for health services and created efficiencies within the clinic. Providers felt that integration benefited them because they learned a wider range of skills but noted that this way of practicing was more taxing than focusing on a single health topic. Going forward, there appears to be strong support for service integration and a desire for government leadership in this area.

Recommendations

Suggested areas of emphasis for future projects

Based on data from the interviews and focus groups, as well as input gathered during the dissemination workshop, areas of emphasis for future investments are recommended. These recommendations fall under each of the WHO's six building blocks of health systems, as well as a behavior change.

- **Leadership and governance:** Consider establishing a national behavior change communication policy. Create a national tool for integrating services. Develop a national protocol to inform the population about contraceptive methods. Strengthen the capacity of existing community-based structures to improve local health governance models.
- **Service delivery:** Build on Tubiteho's achievements in promoting integration, particularly the integration of SGBV and health services. Improve access by constructing and rehabilitating health centers. Establish national quality standards and consider establishing a health facility accreditation system. Promote public/private partnerships for health service delivery.
- **Financing:** Support health financing initiatives including insurance schemes.
- **Workforce:** Improve health worker satisfaction and remuneration, which could impact turnover, attitudes, and productivity. Consider performance-based financing as a possible approach. Develop community health programs for rural and marginalized populations.
- **Medical products:** Establish a system by which medical equipment is continuously available in health facilities. Strengthen the drug supply chain to avoid shortages.
- **Information systems:** Continue to improve data quality and increase the use of data in planning and management. A future project could consider supporting a digitized system of medical records, improving Burundi's epidemiological surveillance systems, and implementing or strengthening systems for tracking and managing staff movement, equipment, and commodities.
- **Behavior change:** Develop tailored social and behavior change strategies, including communication-based strategies to engage religious leaders and other influential stakeholders and involve them in awareness raising. Continue to emphasize male engagement and integration for FP and GBV in health messaging.

Designing future projects—Considerations for localization and sustainability

Those designing future projects could consider several lessons learned regarding localization and sustainability during the implementation of Tubiteho.

The establishment of a joint planning system, led by the Ministry of Health, and including USAID, IPs, and other health actors in Burundi would help to align priorities and harmonize the various approaches.

From the beginning, future projects should plan to transfer ownership of various responsibilities, particularly supervision, from the IP to the districts over the course of the project. This would help ensure that activities were sustained past the end of the project. Further, commitment from the Ministry of Health to mobilize its staff, at all levels, to participate in the project is key.

Lessons learned for project management

A number of lessons learned from the implementation of Tubiteho could inform the management of future health programs in Burundi.

First, if possible, engage the MOH from the start of the project. While USAID's ability to engage with the MOH at the start of Tubiteho was limited due to the United States Government's trafficking-in-persons restrictions, which prohibit US-funded activities from collaborating with the country's government, those restrictions have since been lifted. Informants appreciated that USAID encouraged the project to align with MOH priorities and asked that this approach continue in future projects.

There is an opportunity to improve project performance by strengthening the relationship between the USAID Mission and the IPs. Beginning in the planning phase, expectations for a productive partnership could be developed. This could include roles, responsibilities, and ways of working together, with the goal of co-creating the intervention and co-owning its success.

Tubiteho project activities were at times delayed by the workplan approval process. USAID could explore whether that process could be made more efficient.

The human and financial resources necessary for implementing a large, integrated health project in Burundi may have been underestimated. While Tubiteho had a single coordinator in the northern and southern regions, future projects should ensure that there are sufficient numbers of project staff, particularly at the province and district level. Further, budgeting to meet facilities' equipment and maintenance needs and for adequate numbers of vehicles and unforeseen costs (such as inflated fuel costs) is necessary.

Tubiteho's consortium model was appreciated. Informants recommended continuing joint planning and supervision among the focal area staff but stressed that sufficient timelines for capacity strengthening of local partners must be taken into account.

Lastly, in order to give the project an opportunity to course-correct, a midpoint evaluation should be considered. As this would likely involve data from the routine health information system, USAID could consider supporting a data quality assessment.

Conclusion

Tubiteho made progress in supporting integrated health service delivery in Burundi. Future investments should build on that foundation to continue improving service delivery while shifting to sustainable, health system strengthening interventions with an increased focus on tailored health communication and behavior change. Further, it remains important for the MOH to lead in terms of standards, coordination, and funding.

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Appendix 1. Discussion guides

FGD/Agents de santé communautaire

1. Quelle est votre role dans l'amélioration de la santé dans les domaines suivants :

- PF, SMI, Paludisme, VBG, Nutrition?

2. Quel est votre principal rôle dans votre communauté dans le diagnostic à temps des maladies, dans leur gestion et dans les références aux services de santé ?
    a. Demander ce qu'implique ce rôle, comment il fonctionne, etc.
3. Comment collaborez-vous avec le CDS ? Comment êtes-vous associés dans la planification et l'évaluation des activités du CDS ?
    a. Participez-vous aux processus de prise de décision visant à améliorer les services de santé proposés ?
4. Quelles sont les supervisions/encadrements bénéficiez-vous du personnel du CDS de votre ressort ?
    a. Qu'est-ce qui fonctionne bien dans la façon dont vous collaborez avec les installations et qu'est-ce qui devrait être amélioré ?
    b. Comment aidez-vous les CDS à prendre des décisions qui aideront la communauté à améliorer sa santé ?
5. Quels sont les principaux changements observés avec la mise en œuvre du projet Tubiteho?
    a. Au niveau des formations sanitaires (la qualité des soins, l'accès aux traitements, etc.)
    b. Au niveau de la communauté (connaissances, croyances, attitudes, normes sociales, etc.)
    c. PF, paludisme, SMI, nutrition, VBG
6. De votre point de vue, qu'est-ce qui n'a pas changé malgré les efforts du projet ?
7. Quels sont les principaux défis rencontrés dans l'exercice de votre travail ? Comment pourraient-ils être résolus ?

FGD/Agents communautaires pour la prévention des VBG

1. Quelle est votre contribution dans la prévention et la prise en charge des VBG ?
2. Quel est votre principal rôle dans votre communauté dans le diagnostic à temps des cas de VBG et dans la référence des cas pour une prise en charge appropriée ?
    a. Demander ce qu'implique ce rôle, comment il fonctionne, etc.
3. Comment collaborez-vous avec le CDS et d'autres services en charge de la prévention et la prise en charge des VBG ? Comment êtes-vous associés dans la planification et l'évaluation des activités en rapport avec les VBG ?
    a. Participez-vous aux processus de prise de décision visant à améliorer les services de santé proposés ?
4. Quelles sont les supervisions/encadrements bénéficiez-vous du personnel du CDS ou du référent communal en charge de la prévention des VBG de votre ressort ?
    a. Qu'est-ce qui fonctionne bien dans la façon dont vous collaborez avec les installations et qu'est-ce qui devrait être amélioré ?
    b. Comment aidez-vous les CDS à prendre des décisions qui aideront la communauté à améliorer sa santé ?
5. Quels sont les principaux changements observés avec la mise en œuvre du projet Tubiteho?
6. De votre point de vue, qu'est-ce qui n'a pas changé malgré les efforts du projet ?
7. Quels sont les principaux défis rencontrés dans l'exercice de votre travail ? Comment pourraient-ils être résolus ?

FGD/Femmes/Hommes (parents d'au moins un enfant de moins de 5 ans)

1. Lorsque vous ou un membre de votre foyer vous sentez malade, que faites-vous ou que fait-il habituellement pour se sentir mieux ?
    a. Où cherche-t-on d'abord à se faire soigner ?
    b. Qui participe à la décision de se faire soigner dans un établissement de santé ?
2. Quelles sont les principales difficultés rencontrées dans votre communauté en matière d'accès aux soins de santé, particulièrement pour les femmes et les enfants ?
3. Quelles sont les principales activités menées par les ASC dans votre communauté ?
    a. S'ils n'en parlent pas eux-mêmes, demandez-leur s'ils peuvent être orientés vers le CDS.
4. Comment appréciez-vous la contribution des ASC dans l'accès aux services de santé ?
5. Comment les hommes de votre localité appréhendent l'usage ou le recours à la PF ?
6. Comment les femmes de votre localité appréhendent l'usage ou le recours à la PF ?
7. Comment les leaders religieux ou les autres leaders de votre localité appréhendent l'usage ou le recours à la PF ?
8. Quelles sont les principales activités menées pour lutter contre les VBG dans votre communauté ?
9. Quelles sont les principales activités menées pour améliorer une prise de décision consensuelle au sein du couple/ménagé ?
10. En pensant à ce qui se passe généralement dans votre communauté, si un couple a des problèmes conjugaux et qu'une femme subit des violences, que peut-elle faire pour obtenir de l'aide ?
    a. Qui peut l'aider, où irait-elle ? que pourrait-elle faire ?
11. Depuis 4 ans, quels sont les principaux changements observés dans l'accès aux services des soins particulièrement pour les femmes et les enfants observables dans votre localité (approfondir sur la SMI, la PF, le Paludisme et la Nutrition) ?
12. Avez-vous le sentiment que vos besoins en matière de santé sont entendus et pris au sérieux lorsque vous vous rendez dans un CSA ou un centre de santé ? Avez-vous l'occasion de vous engager auprès des services de soins de santé et d'assistance médicale pour améliorer la santé de votre communauté ?
    a. Y a-t-il quelqu'un à qui vous pouvez parler si vous n'êtes pas satisfait aves les services fournis?
13. Avez-vous entendu parler du projet Tubiteho ?
    a. De quelle manière le projet a-t-il pris en compte vos besoins en matière de santé ?
    b. Comment le projet a-t-il sollicité votre point de vue sur ce qui pourrait être fait pour améliorer les services fournis ?
    c. Comment le projet peut-il améliorer l'intégration des perspectives de votre communauté dans sa mise en œuvre ?

In-depth Interview (IDI)/Responsable communal VBG

1. Veuillez décrire votre rôle au sein de la commune.
2. Pouvez-vous décrire votre engagement dans le projet ?
    a. De quelles manières avez-vous interagi ou participé au projet ?
    b. Comment le personnel du projet s'est-il engagé avec vous et d'autres parties prenantes dans cette commune ?
    c. Quels types d'activités le projet a-t-il facilités / avez-vous réalisés avec le soutien du projet ?
    d. Comment percevez-vous la collaboration avec le projet Tubiteho ?
    e. D'après votre expérience, les perspectives de la communauté locale ont-elles été prises en compte lors de la mise en œuvre ?
3. Comment ce projet a-t-il contribué à la disponibilités des services ?
4. Quelles sont les contributions du projet en matière de l'amélioration de la qualité des services pour la prévention et la prise en charge des VBG ?
5. De quelle manière le projet a contribué dans l'amélioration de la prévention et la prise en charge des VBG ?
6. Quelles sont ses contributions dans la détection précoce des VBG, dans leur prise en charge et dans l'amélioration des références ?
7. Comment les communautés locales ont-elles été impliquées dans les activités du projet pour améliorer l'accès aux services VBG ?
8. Selon vous, qu'est-ce que le projet a pu accomplir au cours des quatre dernières années ?
9. De votre point de vue, qu'est-ce qui n'a pas été accompli ?
10. Quelles difficultés avez-vous rencontrées lors de la mise en œuvre du projet ?
11. Quels sont, selon vous, les défis rencontrés par le projet en matière de mise en œuvre ?
12. De quelle manière le projet a contribué dans l'amélioration de la prévention et la prise en charge des VBG ?

In-depth Interview (IDI)/Hospital Director, Health center Director, Providers/TPS

1. Veuillez décrire votre rôle au sein de [l'hôpital, le centre].
    a. Comment collaborez-vous avec le Projet Tubiteho ?
    b. Pouvez-vous décrire différents cas d'interaction avec le projet (réunions, formations, etc., à quelle fréquence) ?
2. Comment le personnel du projet s'est-il engagé avec vous et d'autres parties prenantes dans ce district ?
3. Quand les activités de Tubiteho ont-elles commencé dans cet [hôpital, établissement, etc.] ?
    a. En quoi les activités diffèrent-elles selon les domaines de santé ?
4. De votre point de vue, comment les activités du projet Tubiteho ont-elles contribué, le cas échéant, à l'amélioration de l'accès aux services de santé dans ce district ?
    a. Comment ce projet a-t-il contribué à la disponibilités des services ?
    b. Quelles sont ses contributions dans le diagnostic précoce des maladies, dans la prise en charge et dans l'amélioration des références ?
    c. Quelles sont ses principales réalisation dans la création de la demande et l'usage à temps des services de santé ?
    d. De quelle manière le projet a contribué dans l'amélioration de la gestion et de la gouvernance des services de santé ?
    e. Quelles sont les contributions de Tubiteho dans l'accès et l'usage des directives cliniques et de l'OMS dans la prise en charge des maladies ?
    f. Quelles ont été les contributions du projet à l'assurance de la qualité des données ?
    g. Comment les données sont-elles utilisées pour prendre des décisions concernant l'amélioration des services ?
5. En quoi les contributions que vous avez mentionnées ci-dessus diffèrent-elles selon la zone de santé ?
    a. Planification familiale ?
    b. Santé maternelle et infantile ?
    c. Paludisme ?
    d. Nutrition ?
    e. VBG ?
    f. L'amélioration de la qualité des services ?
6. Comment est-ce que le projet Tubiteho a impliqué votre hôpital dans le processus de prise de décision ?
7. De quelle manière le projet a-t-il pris en compte les besoins spécifiques de votre hôpital ou votre population ?
8. En quoi le projet a-t-il contribué à l'encadrement des communautés pour une bonne amélioration de la santé particulièrement chez les femmes et les enfants ?
9. Dans quelle mesure avez-vous été en mesure de fournir un retour d'information au projet ou de participer à la prise de décision ?
    a. Comment le projet a-t-il contribué au processus des décisions locales ?
10. Comment appréciez-vous les résultats du projet en matière d'accès et de disponibilité des services de santé de qualité ?

In-depth Interview (IDI)/Médecin Directeur du Bureau Provincial de la Santé

1. Selon vous, quels sont les objectifs de Tubiteho ?
2. Quelles ont été ses principales activités ?
    a. Sondez les cinq domaines.
3. Dans quelle mesure la conception/les objectifs de Tubiteho se sont-ils alignés sur vos priorités ? Qu'est-ce qui manque ?
4. Parlez-moi des relations de Tubiteho avec le ministère de la Santé au niveau de la province et du district et avec d'autres représentants du gouvernement. Quel soutien leur avez-vous apporté et quel soutien ont-ils apporté au projet ? Comment décririez-vous ces relations ?
5. Comment le projet collabore-t-il avec l les formations sanitaires ?
6. Quels sont les principaux appuis fournis aux districts, aux établissements de santé et aux communautés pour faciliter l'accès et l'utilisation des services de santé de qualité ?
7. Comment le projet a-t-il contribué à la création de la demande et l'utilisation à temps des services de santé ?
8. Comment le projet a-t-il contribué dans l'amélioration des systèmes de gestion au niveau des établissements sanitaires (flux ou circuit des patients, triage, etc.) ?
9. Quelles ont été ses principales réalisations en matière d'encadrement des communautés pour atteindre ses objectifs ?
10. Quelles ont été ses principales contributions pour renforcer le système de suivi-évaluation au niveau du district ?
11. Quelles sont les activités entreprises pour que les interventions du projet soient durables ?
12. Quelles sont les innovations, meilleurs pratiques ou leçons peut-on capitaliser, issues de la mise en œuvre du projet ?
13. Quelle est votre appréciation du niveau d'appropriation du district des activités du projet ?
14. Quelles sont les meilleurs pratiques /réalisations ou approches qui pourraient être dupliquées ailleurs pour plus de résultats ?
15. Comment le projet a-t-développé /renforcé le partenariat avec les différents parties prenantes (public, privé, ONG, OSC etc.) ?
16. De quelle manière Tubiteho vous a-t-il informé de ses activités et de ses réalisations ? Dans quelle mesure avez-vous été satisfait du niveau de communication et de collaboration de Tubiteho avec votre bureau ?
    a. Sondez le format (réunions, rapports), les types de données, la fréquence.
17. Quelles informations supplémentaires souhaiteriez-vous obtenir sur le projet ? Comment/pourquoi seraient-elles utiles ?

Key Informant Interview (KII)/ Responsable du Projet à PSI

1. Selon vous, quels sont les objectifs du projet Tubiteho ?
2. Quelles ont été ses principales activités ?
    a. Sondez les cinq domaines.
3. Veuillez décrire votre rôle au sein du projet Tubiteho.
4. Quels sont les partenaires/groupes communautaires, OSC impliqués dans la mise en œuvre du projet avec qui vous avez collaboré ? Pourriez-vous décrire en quoi consistait la collaboration ?
5. Quelle a été la contribution du Projet Tubiteho dans l'amélioration et l'accès aux services de santé dans votre zone d'intervention pour la prise en charge du paludisme /PF/SMI/VBG/nutrition ?
    a. Quelle a été la contribution du projet pour que les services de prise en charge du paludisme/PF/SMI/VBG/nutrition soient fournis en respectant les directives nationales ainsi que les normes de l'OMS ?
    b. Quelle a été la contribution du projet dans le diagnostic précoce/ou à temps du paludisme /PF/SMI/VBG/nutrition, la gestion des cas diagnostiqués et les références pour les services de prise en charge ?
6. Comment avez-vous collaboré avec les établissements sanitaires pour une bonne prise en charge du paludisme/PF/SMI/VBG/nutrition ?
7. Comment appréciez-vous les résultats atteints avec votre projet dans la création de la demande et l'utilisation des services ainsi que le changement de comportement pour une bonne prise en charge du paludisme/PF/SMI/VBG/nutrition ? Quelles sont les évidences qui soutiennent votre appréciation ?
    a. Quelles sont les meilleurs pratiques/réalisations ou approches qui pourraient être dupliquées ailleurs pour plus de résultats ?
    b. Quels sont les facteurs positifs/atouts qui ont contribué à l'amélioration de vos résultats ?
    c. Quels sont les facteurs/contraintes que vous avez rencontrés et qui auraient limité la réalisation ou l'atteintes de vos objectifs dans ce domaine ?
8. Comment le projet utilise-t-il les données pour contrôler la mise en œuvre, prendre des décisions ou rendre des comptes aux parties prenantes ?
    a. Pouvez-vous me donner des exemples ?
9. Dans quels domaines pensez-vous que la performance du projet a été la plus forte ? Les plus faibles ?
    a. Comment le savez-vous ? Quelles sont les données auxquelles vous avez accès ?
    b. Quelles données supplémentaires souhaiteriez-vous avoir sur le projet ? Comment/pourquoi seraient-elles utiles ?
10. Que signifie pour vous le fait qu'il s'agisse d'un projet de santé intégré ?
11. Dans quelle mesure chaque domaine a-t-il été intégré aux autres ?
    a. Donnez quelques exemples tirés de l'examen des documents
    b. S'il n'y a pas eu beaucoup d'intégration, pourquoi ?
12. Pouvez-vous décrire les difficultés rencontrées lors de la mise en œuvre d'un projet de santé intégré ?
    a. Dans quelle mesure ces difficultés ont-elles entravé la réalisation des objectifs du projet ? Veuillez développer...
13. Pouvez-vous décrire les avantages de l'intégration de la santé ? Pour les responsables de la mise en œuvre, les autres parties prenantes, la communauté ?
14. En ce qui concerne la gestion et la mise en œuvre du projet, qu'est-ce qui a bien fonctionné et qu'est-ce qui n'a pas bien fonctionné ?
    a. Gouvernance : Coordination avec les autorités locales

b. Ressources humaines : Plan de recrutement, pourvoi des postes, rotation, supervision, satisfaction des employés
c. Finances : Adéquation, opportunité, mode d'affectation
d. Information : Avez-vous eu les informations nécessaires pour planifier et adapter vos programmes ?
e. Prestation de services : Avez-vous eu la flexibilité nécessaire pour adapter vos programmes ? Avez-vous tiré des leçons de la coordination au sein de votre organisation et entre les responsables de la mise en œuvre ? Qu'en est-il de la collaboration avec les sites (hôpitaux, centres de santé, etc.) ?
f. Matériel : Dans quelle mesure les ruptures de stock ont-elles affecté votre travail ?

15. Quels sont les enseignements tirés de la gestion de ce projet qui devraient être pris en compte pour la suite de ce projet ? Pour les projets futurs ?

Key Informant Interview (KII)/ Pathfinder

Project Design & Evolution

1. What are the objectives of Tubiteho?
2. Tell me the high-level story of the program. What have been the major milestones and challenges over the course of the project?
    a. Probe: COVID, election, change in USAID leadership
3. (Show the logic model or a Theory of Change diagram.) This was the original logic model/TOC for this project. How has the project evolved since the initial design? What changes would you make to this diagram so that it describes the program today?
4. How has your approach differed between the northern and southern regions?
    a. Have there been challenges specific to the northern or southern regions?
    b. Have there been factors that facilitated the project in either the northern or southern regions?
5. Tell me about Tubiteho's relationship with the central-level Ministry of Health? What support have you given them, and what support have they given to the project? How would you describe the relationship?
    a. Technical support
    b. Financial support
    c. Management/coordination support
6. Tell me about Tubiteho's relationship with the provincial and district-level Ministry of Health and other government officials? What support have you given them, and what support have they given to the project? How would you describe the relationship?
7. What have you done to ensure that Tubiteho aligns with government/MOH priorities?
    a. Have there been any cases of misalignment between USAID and MOH priorities? How have you handled them?
8. What have been the benefits and drawbacks/challenges in coordinating with other health projects operating in Burundi?
9. What has been your methodology for determining which districts/facilities/communities get a particular intervention?

Project Integration

10. What does it mean to you that this is an integrated health project?
11. To what extent was each area integrated with the others?
    a. Have some examples from the document review
12. If not much integration, why?
13. Can you describe any challenges experienced implementing an integrated health project?
    b. To what extent have these challenges hindered achieving the project objectives? Please expand...
14. Can you describe any benefits from health integration? For the implementers, other stakeholders, the community?

Local Perspectives

15. In 2020, Tubiteho conducted workshops with local stakeholders to introduce the project and seek their recommendations for how best to implement the project. How have you used their feedback?
16. How has feedback collected through Community Scorecards been used…
    a. To inform the project?
    b. By the government/MOH?

c. By facilities?
d. By communities?

17. What mechanisms are in place for Tubiteho to be accountable to local stakeholders? What data are shared?

Project Management

18. How has Pathfinder built capacity within CEPBU and Association Dushirehamwe? How have priorities for capacity strengthening been set? How have they been measured?
19. Thinking about project management and implementation, what worked well, and what didn't work well?
    a. Governance: Coordination/relationship with USAID, local government
    b. Human resources: Staffing plan, filling positions, turnover, supervision, employee satisfaction
    c. Finances: Adequacy, timeliness, how allocated
    d. Information: Did you have the info you needed to plan and adapt your programs?
    e. Service delivery: Did you have the flexibility you needed to adapt your programs? Any lessons from coordination within your organization and across implementers? What about working with sites (hospitals, health centers, etc.)?
    f. Materials: Getting needed commodities into and throughout the country.
20. What additional data would you like to have about the project? How/why would they be useful?
21. What are the lessons learned from the management of this project that should be considered for the remainder of this project? For future projects?

Sustainability

22. How do you think about sustainability in terms of this project?
    a. What activities/achievements have potential to be sustained without outside support?
    b. Which would require continued support?
23. What has been your strategy for ensuring that what has potential to be sustainable is sustained?
24. To what degree have the districts taken ownership of activities that Tubiteho implemented?
    c. What are they "owning?"
    d. What aren't they "owning," and why?
25. In your view, what activities have the potential for scale-up outside of Tubiteho-supported areas? Have you seen any evidence that this will happen? Why or why not?
26. What are the challenges that prevent the sustainability of project activities and results achieved?

Key Informant Interview (KII)/ USAID

Project Design & Evolution

1. What has been your involvement with Tubiteho?
    a. Conception and design (probe)
    b. Management
    c. When and how the AOR transition happened
2. What was the process for designing Tubiteho? Who participated in the design? To what extent was it aligned with USAID Burundi priorities? How has that alignment shifted over the course of the project?
    a. Probe: MOH - at what point(s) did they get involved?
3. How were the provinces selected?
4. What was the process for determining which districts/facilities/communities got a particular intervention?
5. What does it mean to you that this is an integrated health project? How was integration conceptualized?
6. Tell me the high-level story of the implementation of the program. What have been the major milestones and challenges over the course of the project?
    a. Probe: COVID, election, change in USAID leadership
    b. Probe: Timeline
7. Tell me about USAID's relationship with the central-level Ministry of Health? How would you describe the relationship?
    a. Same question about Tubiteho/Pathfinder and MOH
8. Tell me about USAID's relationship with the provincial and district-level Ministry of Health? How would you describe the relationship?
    a. Same question about Tubiteho/Pathfinder and MOH
9. What have you done to ensure that Tubiteho aligns with government/MOH priorities?
    a. Have there been any cases of misalignment between USAID and MOH priorities? How have you handled them?
10. What was the expectation for Tubiteho to coordinate with other health projects operating in Burundi? Were those expectations met?
    a. Probe: USAID and non-USAID

Local Perspectives

11. What was the expectation for Tubiteho to be accountable to local stakeholders? To what extent was it met?
    a. Probe: Did anything change after USAID localization strategy was released in 2022?

Project Management

12. Thinking about project management and implementation, what worked well, and what didn't work well?
13. What are the lessons learned from the management of this project that should be considered for future projects in Burundi?

Sustainability

14. What were the expectations for ensuring sustainability? To what extent were they met?

Appendix 2. Tubiteho's internal monitoring data

Tubiteho's Performance Indicators FY24 (October 2023–May 2024). T=target, **A**=achievement, **green** shading = met or exceeded target, **orange** = did not meet, **grey** = either target or achievement was not applicable or not available, so no comparison possible.

#	Key Performance Indicators	Disaggregation	Baseline source	Year 1		Year 2		Year 3		Year 4		Year 5	
				T*	A*	T*	A*	T*	A*	T*	A*	T*	A*
Goal: Health of Burundians, especially improved for women, children, and infants													
1	Maternal mortality, per 100,00 live births	Age, place of residence	DHS 2016–2017	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2	Infant (<12 months) mortality, per 1,000 live births	Place of residence, sex, socioeconomic status	DHS 2016–2017	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3	Child (<5) mortality, per 1,000 live births	Place of residence, sex, socioeconomic status	DHS 2016–2017	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
4	Total fertility rate	Place of residence, socioeconomic status	DHS 2016–2017	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
5	Anemia (children under 5 and women aged 15–49 years)	Age, place of residence, sex, socioeconomic status:	DHS 2016–2017	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Purpose: Increased use of quality health systems													
6	Modern contraceptive prevalence rate	Total	DHS 2016–2017		N/A	N/A	N/A	N/A	N/A	N/A	N/A	25%	N/A
7	Malaria case fatality rate	Hospital	DHIS2 FY19	N/A	1.4%	N/A	1.0%	0.2%	0.7%	0.2%	1%	0.2%	1.2%
		Health center		N/A	0.070%	N/A	0.001%	0.001%	0.001%	0.001%	0.001%	0.001%	0.001%
Intermediate Result 1: Access to Quality Essential Health Services Increased													
8 HL.7.1-1	Couple years of protection (CYP) in USG-supported programs	Total	DHIS2 FY19	N/A	248,833	265,422	272,388	285,669	293,231	302,873	317,597	211,731	186,398

#	Key Performance Indicators	Disaggregation	Baseline source	Year 1		Year 2		Year 3		Year 4		Year 5	
				T*	A*	T*	A*	T*	A*	T*	A*	T*	A*
9	Estimated potential beneficiary population for maternal, newborn, and child survival program	Total	ISTEEBU (February 2020)	1,047,898	1,047,898	1,053,471	1,053,471	1,058,742	1,058,742	1,063,735	1,068,776	1,068,776	1,068,776
10	% of supported facilities that provide a core/ expanded package of quality integrated health services	Northern provinces	Tubiteho's health facility assess-ment (March 2020)	N/A	78.60%	+5%	85.39%	95%	86.2%	90%	N/A	95%	87.3%
		Southern provinces			79.50%		79.24%	95%	83.93%	87%	N/A	95%	86.7%
11	% of supported health centers with CHWs that provide core package of quality integrated health and support services	Northern provinces	Tubiteho's health facility assess-ment (March 2020)	N/A	86.50%	+7%	88.48%	95%	90.83%	95%	N/A	95%	89.3%
		Southern provinces			72.70%		79.51%	90%	82.17%	95%	N/A	95%	88.3%
12	% of health centers that have functional CHW systems	Northern provinces	Tubiteho's health facility assess-ment (March 2020)	N/A	80.80%	90%	83.61%	94%	83.27%	95%	N/A	95%	82.6%
		Southern provinces			68.90%	78%	72.99%	83%	76.47%	90%	N/A	90%	82.8%
Intermediate Result 2: Adoption of Positive Health Behaviors Increased													
13	% of women and men who believe that young women (aged 13–18 years) should use an FP method if they choose to do so	Northern provinces	IHPB final report 2018	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
		Southern provinces	Tubiteho's household survey (September 2021)	N/A	N/A	N/A	F: 37% M: 41%	N/A	N/A	N/A	N/A	N/A	N/A
14	% of women seen by a health provider within the first 48 hours following delivery	Total	DHIS2 FY19		7.7%	20%	27.60%	76%	74.5%	85%	99.3%	100%	97.6%
15	% of children who were exclusively breastfed until 6 months of age	National average	DHS 2016–2017	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	89%	N/A

#	Key Performance Indicators	Disaggregation	Baseline source	Year 1		Year 2		Year 3		Year 4		Year 5	
				T*	A*	T*	A*	T*	A*	T*	A*	T*	A*
16	# of people reached through awareness-raising sessions on exclusive breastfeeding	Total	N/A	N/A	246,249	250,000	228,728	251,601	266,940	272,000	71,340	N/A	N/A
Intermediate Result 3: Strengthened Health Systems for Health Service Delivery													
17	% of facilities that demonstrably use facility- and community-level data for timely decision making	Total	PBF results at the provincial level FY19	N/A	47%	N/A	43%	49%	49%	61%	56%	66%	ND
Sub-IR 1.1: Availability of quality FP, MCH, Malaria, Nutrition, and GBV services increased													
FP and Reproductive Health (RH)													
18 HL.7.1-2	% of USG-assisted service delivery sites providing FP counseling and/or services	Northern provinces	Tubiteho's health facility assessment (March 2020)	+5%	94.0%	98%	89.0%	100%	95.5%	100.0%	99.4%	100.0%	99.4%
		Southern provinces			90.2%	96%	88.9%	100.0%	93.7%	100%	100%	100%	100%
19	# of PLHIV in supported HIV delivery points and facilities using at least a modern FP method during reported period	Total	N/A	N/A	N/A	3,200	414	1,242	666	800	563	666	159
Maternal/Child Health													
20	% of pregnant women who completed 8 ANC visits	Total	N/A	N/A	N/A	1%	N/A	1%	N/A	1%	0.05%	0.08%	0.16%
21 HL.6.2-2	# of women giving birth in a health facility receiving USG support	Total	DHIS2 FY19	N/A	166,275	172,000	162,656	183,660	166,210	174,529	163,472	108,981	124,192
22 HL.6.2-1	# / % of women giving birth who received uterotonics in the 3rd stage of labor (or immediately after birth) through USG-supported programs	Total	N/A	99,315	110,476	160,000	98.4%	100%	99.1%	100%	98%%	100%	93.5%

#	Key Performance Indicators	Disaggregation	Baseline source	Year 1		Year 2		Year 3		Year 4		Year 5	
				T*	A*	T*	A*	T*	A*	T*	A*	T*	A*
23 HL.6.3-63	# of newborns who received postnatal care within two days of childbirth in USG-supported programs	Total	DHIS2 FY19	N/A	15,330	22,000	44,899	110,196	120,279	132,307	158,521	116,249	120,405
24 HL.9-3	# of pregnant women reached with nutrition interventions through USG-supported programs	Total	N/A	N/A	233,355	518,080	536,053	598,546	513,906	552,417	314,524	161,651	194,656
	Counseling on maternal and/or child nutrition and during pregnancy	Total	N/A	N/A	233,355	250,000	237,663	261,429	256,310	281,941	72,047	N/A	N/A
	Iron supplementation	Total	N/A	N/A	N/A	268,080	298,390	337,117	257,596	270,476	242,477	161,651	194,656
25 HL.6.3-1	# of newborns not breathing at birth who were resuscitated in USG-supported programs	Total	N/A	15,630	1,183	1,800	1,023	1,125	1,214	1,335	1,443	1058	982
26 HL.6.6-1	# of cases of child diarrhea treated in USG-assisted programs	Total	DHIS2 FY19	28 000	23,019	25,000	26,863	29,549	39,503	46,561	95,553	74,103	102,203
27 3.1.6-61	#/ % of children who received DPT3 by 12 months of age in USG-assisted programs	Total	DHIS2 FY19	87%	94.1%	95%	107.9%	143,153	142,027	143,153	137,385	91,590	97,668
28 HL.6.4-62	#/% of children who received their first dose of measles-containing vaccine (MCV1) by 12 months of age in USG-assisted programs	Total	DHIS2 FY19	N/A	98.80%	98%	107.3%	142,795	139,734	142,795	133,828	89,219	98,669
Malaria													
29	Proportion of reported malaria cases that are confirmed with a diagnostic test at public-sector health facilities	Total	DHIS2 FY19	+5%	95.7%	100%	99.6%	100%	99.5%	100%	100.0%	100%	100%

#	Key Performance Indicators	Disaggregation	Baseline source	Year 1		Year 2		Year 3		Year 4		Year 5	
				T*	A*	T*	A*	T*	A*	T*	A*	T*	A*
30	Proportion of malaria cases (presumed and confirmed) that received first-line antimalarial treatment at public-sector health facilities	Total	DHIS2 FY19	+5%	79.6%	95%	90.5%	100%	95.9%	100%	97.9%	100.0%	97.9%
31	Proportion of pregnant women who received at least 3 doses of DOT intermittent preventive treatment (IPT) for malaria during ANC visits	Total	DHIS2 FY19	+5%	62.7%	70%	52.7%	62.7%	54.9%	60.3%	65.6%	71.0%	57.6%
32	Proportion of pregnant women who received at least 5 doses of DOT intermittent preventive treatment (IPT) for malaria during ANC visits	Total	N/A	N/A	N/A	1%	N/A	1%	ND	1%	9.5%	10.0%	14.4%
33	% of patients with suspected malaria receiving a diagnostic test	Total	DHIS2 FY19	100%	99.7%	100%	99.7%	100%	99.8%	100%	100.0%	100.0%	100%
34	Number of long-lasting impregnated insecticide-treated mosquito nets (LLINs) distributed (during ANC and childhood vaccination)	Total	N/A	N/A	N/A	N/A	N/A	350,627	93%	95%	95.5%	100.0%	95.2%
	# of ITNs distributed during ANC service visits	Total	N/A	N/A	N/A	N/A	N/A	207,832	89%	95%	96.3%	100%	93%
	# of ITNs distributed during child vaccination visits	Total	N/A	N/A	N/A	N/A	N/A	142,795	98.8%	95%	98%	100%	98%
35	% of confirmed malaria cases receiving effective malaria treatment according to standard national protocols	Total	End-use verification surveys FY19	80%	81.30%	85%	83.8%	89%	84.3%	89%	N/A	89%	N/A
Nutrition													

#	Key Performance Indicators	Disaggregation	Baseline source	Year 1		Year 2		Year 3		Year 4		Year 5	
				T*	A*	T*	A*	T*	A*	T*	A*	T*	A*
36 HL.9-1	# of children under 5 (0–59 months) reached by USG-supported nutrition programs	Total	DHIS2 FY19	N/A	258,489	301,000	839,458	923,404	1,338,580	1,642,849	1,197,515	798,343	946,340
37 HL.9-2	# of children under 2 (0–23 months) reached with community-level nutrition interventions through USG-supported programs	Total	DHIS2 FY19	N/A	246,249	250,000	228,691	246,465	324,375	340,594	320,452	213,635	237,856
38 HL.9-4	# of individuals receiving nutrition-related professional training through USG-supported programs	Total	N/A	N/A	830	972	1,256	0	N/A	0	N/A	N/A	N/A
Gender-Based Violence													
39 GNDR-6	Number of people reached by a USG-funded intervention providing GBV services (e.g., health, legal, psycho-social counseling, shelters, hotlines, other)	Total	N/A	200	123	700	652	800	742	800	1020	800	511
40	# of facilities that provide post-exposure prophylaxis to GBV survivors	Total	DHIS2 FY19	20	35	59	293	308	324	307	283	307	309
Sub-IR 1.2: Health Center services (FP, MCH, Malaria, Nutrition, and GBV) provided according to National and WHO guidelines													
41	# of entities (facilities/ groups) receiving TA	Public HFs coached and trained on various topics (FP/ MNCH/ Malaria/ GBV)	N/A	231	136	175	346	412	328	255	109	135	81
		Health facility providers trained on HMIS		366	316	440	367	218	7	180	N/A	N/A	N/A
		Public HFs received service provision tools (e.g., guides, protocols)		231	88	175	332	415	149	223	19	309	308

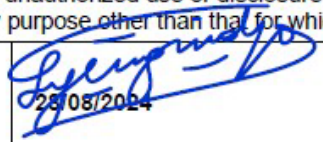
#	Key Performance Indicators	Disaggregation	Baseline source	Year 1		Year 2		Year 3		Year 4		Year 5	
				T*	A*	T*	A*	T*	A*	T*	A*	T*	A*
		GASC trained on various topics		221	168	190	227	161	274	84	109	135	144
		Private HFs supported to integrate with NHIS through DHIS2		19	N/A	19	19	18	N/A	N/A	N/A	N/A	N/A
Gender-Based Violence													
42	# of community-level workers trained in case manage-ment	Total	N/A	447	569	312	1,048	1,719	1,731	450	444	N/A	N/A
Maternal/Child Health													
43 HL.6.6-64	# of cases of childhood pneumonia treated in USG-assisted programs	Total	DHIS2 FY19	N/A	45,952	54,000	50,779	55,857	48,590	55,010	51,379	34,253	35,958
44	# of cases treated by CHWs	Cases of children who received antimalarials within 24 hours	DHIS2 FY19	N/A	352,408	405,000	150,120	165,132	604,330	664,763	468,342	312,228	312,949
		Cases of over-5-years-old who received antimalarials within 24 hours		N/A	N/A		N/A	N/A	118,283	130,111	191,481	127,654	205,305
		Cases of diarrhea treated with zinc and ORS		N/A	14,158	20,250	14,637	15,369	18,260	43,016	30,321	20,214	22,471
Sub-IR 2.1: Demand for FP, MCH, Malaria, Nutrition, and GBV services increased													
45 HL.7.2-2	# of USG-assisted CHWs providing FP information, referrals, and/or services during the year	Total	N/A	2,680	2,884	3,484	3,426	3,909	3,558	3,909	3,557	3,557	3,557
46 HL.7.2-1	% of audience who recall hearing or seeing a specific USG-supported FP/RH	Northern provinces	IHPB final report 2018	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	49.1%	N/A

#	Key Performance Indicators	Disaggregation	Baseline source	Year 1		Year 2		Year 3		Year 4		Year 5	
				T*	A*	T*	A*	T*	A*	T*	A*	T*	A*
	message	Southern provinces	N/A		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
47 HL.7.2-3	Number of individuals in the target population reporting exposure to USG-funded FP messages through radio, television, electronic platforms, community group dialogues, interpersonal communication or in print	Total	N/A	N/A	N/A	162,400	323,740	186,000	51,639	35,200	110,371	73,581	44,437
Sub-IR 2.2: Timely health-seeking behavior for FP, MCH, malaria, nutrition, and GBV services increased													
48	Proportion of children under 5 who have tested positive for malaria with a rapid diagnostic test who received ACT within 24 hours	Total	DHIS2 FY19	80.0%	91.9%	95.0%	97.4%	100%	98.8%	100%	98.2%	100%	98.1%
49	% of pregnant women who receive early ANC	Total	DHIS2 FY19	N/A	41.70%	65%	62.8%	65%	62.8%	65%	64.2%	65%	63.2%
50	# of GBV survivors referred by CHWs to health centers within 24 hours	Total	N/A	N/A	N/A	222	468	600	433	461	521	461	252
Sub-IR 2.3: Gender norms changed to reduce GBV and improve decision making at household level													
51	% of women and men in agreement with the concept that males and females should have equal access to social, economic, and political resources and opportunities	Kirundo	IHPB final report 2018	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	F:59% M: 66%	N/A
		Karusi					N/A	N/A	N/A	N/A	N/A	F:64% M: 68%	N/A
		Muyinga					F:41% M: 43%	N/A	N/A	N/A	N/A	F:51% M: 53%	N/A
		Bururi	Tubiteho's household survey (September 2021)				F:41% M: 34%	N/A	N/A	N/A	N/A	F:46% M: 39%	N/A
		Makamba					F:52% M: 48%	N/A	N/A	N/A	N/A	F:57% M: 53%	N/A

#	Key Performance Indicators	Disaggregation	Baseline source	Year 1		Year 2		Year 3		Year 4		Year 5	
				T*	A*	T*	A*	T*	A*	T*	A*	T*	A*
		Rumonge					F:45% M: 43%	N/A	N/A	N/A	N/A	F:50% M: 48%	N/A
52	# of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public- or private-sector institutions or organizations	Total	N/A	218	119	155	153	216	123	76	74	N/A	N/A
53	% of women and men who are married/ cohabitating that report that they and their spouse make decisions as a couple on how many children they should have	Kirundo	IHPB final report 2018	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	F:67% M: 62%	N/A
		Karusi					N/A	N/A	N/A	N/A	N/A	F:60% M: 62%	N/A
		Muyinga					F:68% M: 74%	N/A	N/A	N/A	N/A	F:73% M: 79%	N/A
		Bururi	Tubiteho's household survey (September 2021)				F:53% M: 61%	N/A	N/A	N/A	N/A	F:58% M: 66%	N/A
		Makamba					F:67% M: 76%	N/A	N/A	N/A	N/A	F:72% M: 81%	N/A
		Rumonge					F:62% M: 64%	N/A	N/A	N/A	N/A	F:67% M: 69%	N/A
Sub-IR 3.1: Management systems (including M&E and Data Management) improved at health-facility and community levels													
54 HL.7.1-3	Average stockout rate of contraceptive commodities at FP service delivery points	Overall	Tubiteho's health facility assess-ment (March 2020)	<15%	9%	< 7%	4%	3%	2.7%	2.5%	3.2%	2.0%	3.1%
55	% of supported facilities that experienced a stockout at any point during the last 3 months	Total	Tubiteho's health facility assess-ment (March 2020)	<20%	12.2%	< 10%	14.1%	10%	10.3%	8.0%	N/A	8%	23.3%
56	% of health centers that meet minimum standards in supply chain management	Total	IHPB final report 2018	90%	88.0%	90%	92.3%	95%	94%	97.0%	96.0%	99.0%	ND

#	Key Performance Indicators	Disaggregation	Baseline source	Year 1		Year 2		Year 3		Year 4		Year 5	
				T*	A*	T*	A*	T*	A*	T*	A*	T*	A*
57	% of COSAs that meet defined functionality standards	Total	Tubiteho's health facility assess-ment (March 2020)	80%	86.4%	90%	86.9%	98.0%	80.6%	85.0%	N/A	85.0%	83.80%
58	% of USG-supported facilities that maintain timely reporting	Total	DHIS2 FY19	95%	96.8%	98%	96.3%	100.0%	99.3%	100.0%	98.7%	100.0%	94.7%
Sub-IR 3.2: Supportive supervision strengthened at community and health-facility levels													
59	Proportion of targeted health facilities that receive supervisory visits	Total	DHIS2 FY19	80%	53.4%	85%	57.6%	68.0%	58.4%	65.0%	74.9%	84.0%	64.2%
Sub-IR 3.3: Referral systems from community through health center to tertiary care improved													
60	% of clients seeking methods not available at private and FBO clinics who were referred	Private HFs	N/A	N/A	N/A	80%	0%	100%	N/A	N/A	N/A	N/A	N/A
		Faith-based HFs				80%	21%	100%	98.3%	100.0%	100%	100%	100%
61	Number of cases referred by CHWs to health centers & referral reason:												
	Cases of pneumonia treated with Amoxicillin referred due to lack of improvement		DHIS2 FY1	N/A	144	150	49	49	6	9	57	4	28
	Treated children who received antimalarials within 24 hours referred due to lack of improvement			N/A	9,159	9,000	97	97	604	507	206	19	88
	Cases of diarrhea treated with zinc and ORS referred due to lack of improvement			N/A	1,682	1,700	2,094	2,094	47	48	105	14	66
Sub-IR 3.4: Increased use of clinical guidelines at health facilities													
62	% of supported facilities that perform to national technical quality standards	Total	N/A	N/A	54.2%	60%	57.3%	65.0%	40%	51%	61%	64%	ND
63	% of supported facilities that have all current national health policies, protocols, and guidelines available	Total	Tubiteho's health facility assessment (March 2020)	60%	56.2%	70%	59.7%	70%	71.6%	75%	N/A	75%	73.5%

Appendix 3. Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	**MUNEZERO DESIRE**
Title	CONSULTANT
Organization	CERPED
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Burundi Tubiteho
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: Real or potential conflicts of interest may include, but are not limited to: 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	Click or tap here to enter text.
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.	
Signature and date	 28/08/2024

Name	Gloria Igihozo
Title	Research Assistant
Organization	Tulane University
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Burundi Tubiteho
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: Real or potential conflicts of interest may include, but are not limited to: 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	Click or tap here to enter text.
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.	
Signature and Date	Gloria Igihozo, 27/08/2024

Name	Janna Wisniewski
Title	Assistant Professor
Organization	Tulane University
Evaluation Position	☒ Team Leader ☐ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Burundi Tubiteho
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: Real or potential conflicts of interest may include, but are not limited to: 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	Click or tap here to enter text.
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.	
Signature and Date	09/04/2024 

Name	**Jean François Régis SINDAYIHEBURA**
Title	**Dr.**
Organization	**Centre de Recherche et d'Etudes en Population et Développement (CERPED)**
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Burundi Tubiteho
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ **No**
If yes answered above, I disclose the following facts: Real or potential conflicts of interest may include, but are not limited to: 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	Click or tap here to enter text.
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.	
Signature and date	Bujumbura, August 28th, 2024  **Dr Jean François Régis SINDAYIHEBURA**

Name	NDAYIZEYE Judith
Title	Professeur associé
Organization	Centre de Recherche et d'Etudes en Population et Développement (CERPED)
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Burundi Tubiteho
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
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Signature and Date	Bujumbura, August 28th,2024 Ndayizeye Judith

Name	Martha Silva
Title	Assistant Professor
Organization	Tulane University
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Burundi Tubiteho
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: Real or potential conflicts of interest may include, but are not limited to: 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	Click or tap here to enter text.
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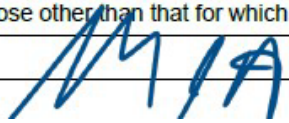
Signature and Date	9/3/2024 

Name	Miriam Makali
Title	Research Assistant
Organization	Tulane University
Evaluation Position	☐ Team Leader ☒ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Burundi Tubiteho
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
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Signature and Date	Miriam Makali 9/2/2024

Name	René MANIRAKIZA
Title	Coordinator
Organization	CERPED
Evaluation Position	☒ Team Leader ☐ Team Member
Evaluation Award Number (contract or other instrument)	Associate award 7200AA18LA00008
USAID Project(s) Evaluated (Include project name(s), implementer name(s), and award number(s), if applicable)	Burundi Tubiteho
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
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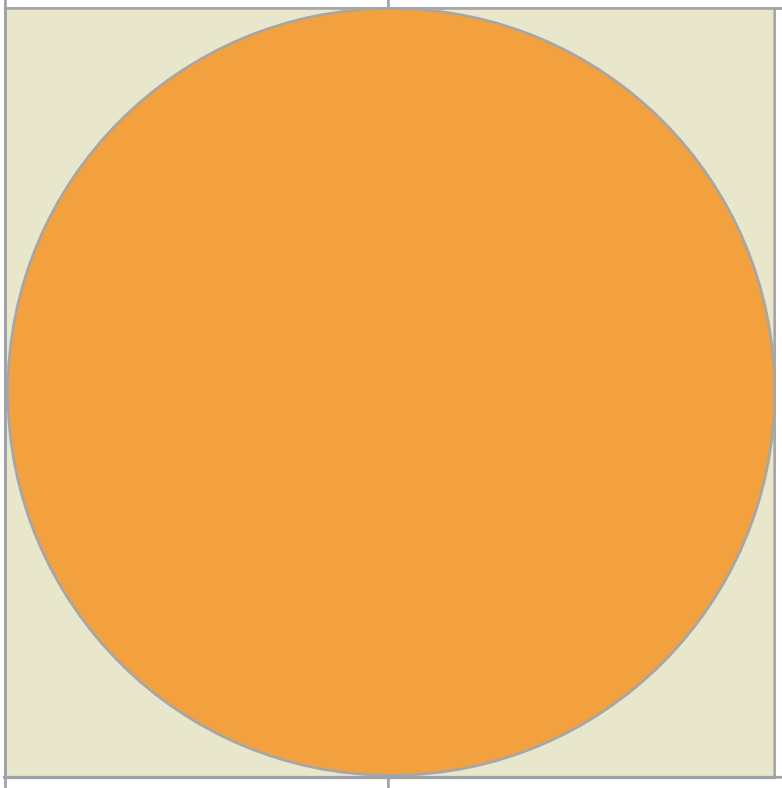
Signature and Date 	August 28th 2024



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