FINAL EVALUATION OF PROSSAN

Program to Strengthen Health Systems and Services in Ivory Coast, Liberia and Sierra Leone (PROSSAN - West Africa)

By:

Action Against Hunger UK

Monitoring, Evaluation, Accountability and Learning Services

Date:

11 July 2022

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SUMMARY TABLE

Action Title	Program to Strengthen Health Systems and Services in Ivory Coast, Liberia and Sierra Leone (PROSSAN - West Africa)
Location	Ivory Coast, Liberia and Sierra Leone
Duration	May 2019 – May 2022
Donor and Contribution/s	Agence française de développement (AFD)
Leading partner	Action contre la Faim (ACF)
Partners	Association des Femmes Juristes de Ivory Coast (AFJCI) Community Association for Psychosocial Services (CAPS) Community Action for the Welfare of Children (CAWeC) Community Health Initiative (CHI) Solidarité Thérapeutique et Initiatives pour la Santé (SOLTHIS) Mission des jeunes pour l'Education, la Santé, la Solidarité et l'Inclusion (MESSI)
Evaluators	Action Against Hunger UK's Monitoring, Evaluation, Accountability and Learning Services[1]
Type of exercise	Final evaluation
Evaluation Dates	April – June 2022

ACKNOWLEDGEMENTS

The evaluation team would like to thank all those who were interviewed for dedicating a portion of their time for this baseline exercise. In particular, thanks are extended to the numerous stakeholders from ACF and its partners who were involved in the data collection activities.

A specific thank goes to Francis Kamara, Egnon Kouakou and Sylvain Dupont for supporting in-country data collection.

This report was commissioned by Action contre la Faim in France. The comments contained herein reflect the opinions of the evaluation team only.

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ACRONYMS

ACF	Action contre la Faim
AFD	Agence française de développement
AFS	Adolescent Friendly Spaces
AFJCI	Association des Femmes Juristes de Côte d'Ivoire
CAPS	Community Association for Psychosocial Services
CAWEC	Community Action for the Welfare of Children
CECom	Cercles d'échange communautaire
CHI	Community Health Initiative
COVID-19	Corona Virus Disease 2019
DHMT	District Health Management Team
DIIS	Direction de l'Informatique et de l'information Sanitaire
EMOC	Emergency obstetric care
FCM	Feedback and Complaint Mechanism
FGD	Focus Group Discussion
FMC	Facility management committee
FSG	Father support group
IGA	Income generating activity
ISSAB	Friends of Babies Sanitary Structure Initiative (*Initiative Structure Sanitaire Amie des Bébés*)
MEAL	Monitoring, Evaluation, Accountability and Learning
MESSI	Mission des jeunes pour l'Education, la Santé, la Solidarité et l'Inclusion
mhGAP	Mental Health Gap Action Programme
MHP	Minimum Health Package
MHPSS	Mental Health and Psychosocial Support
MoHS	Ministry of Health and Sanitation (Sierra Leone)
MHSP	Ministry of Health and Public Hygiene (Ivory Coast)
MoE	Ministry of Education
MoH	Ministry of Health (Liberia)
MSG	Mother support group
PHU	Primary Health Unit
PNSME	Programme National de Santé de la Mère et de l'Enfant
PNSSU-SAJ	Programme National de Santé Scolaire et Universitaire-Santé Adolescents et Jeunes
SHC	School Health Club
SOLTHIS	Solidarité Thérapeutique et Initiatives pour la Santé
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
VSLA	Village Saving and Loans Association

EXECUTIVE SUMMARY

OBJECTIVES AND METHODOLOGY

The purpose of this evaluation is to reflect on the performance of the PROSSAN programme (2019-2022), and to identify lessons learned and recommendations for adaptations in the next phase of implementation. PROSSAN was implemented by Action Against Hunger in Sierra Leone, Liberia and Ivory Coast with local partners to improve the health of vulnerable populations through quality health care services adapted to their specific needs.

This evaluation relies on data collected through key informant interviews with ACF and partner staff, government at the national and district level, health staff, and beneficiaries; focus groups discussions with adult and adolescent community groups; observations of health sites; and a document review.

Table A: Data collection technique by country

	Sierra Leone	Liberia	Ivory Coast
Key informant interviews	x	x	x
Focus group discussions	x		x
Document review	x	x	x
Observations	x		x

FINDINGS

CRITERIA	RATING (1 poor, 5 high)				
Relevance				4	
Coherence			3.7		
Effectiveness			3.3		
Efficiency		2			
Sustainability			3.5		

Relevance

Overall, PROSSAN's objectives and approaches were relevant to the needs and priorities of the governments and target populations of Ivory Coast, Sierra Leone and Liberia respectively. The design and implementation of PROSSAN was closely aligned with the policies and priorities of each country's national government. Most activities were designed based on government approaches and national strategies and implemented in coordination with district and country level authorities focusing on maternal, adolescent and child health. In Sierra Leone and Ivory Coast, government relevance was evident and

successful. In Liberia, the lack of updated government policies on SRH created challenges to ensure activities were aligned.

In general, PROSSAN also addressed the needs of the target populations – both of staff working in health facilities and vulnerable community members. Evidence from implementing staff and beneficiaries indicate that capacity building topics and trainings were useful to fill important gaps in knowledge and skill sets to reduce maternal mortality and improve health practices.

Participatory needs assessments were not consistently conducted in each country of implementation. Activities were designed based on government needs assessments but the lack of systematic engagement with beneficiaries during the design phase resulted in a partial misalignment of priorities. Some respondents note that material support was missing to ensure they were able to implement on the training received, such as the provision of visibility items, medical equipment in health facilities, and transportation subsidies.

Coherence

PROSSAN utilised close partnerships with the governments and local organisations to ensure coherence of activities and to build on the existing work being carried out by local actors in Liberia, Sierra Leone and Ivory Coast respectively. Ultimately, the project was designed by ACF with co-implementors, rather than being co-constructed jointly and equally by ACF and its partners.

Coordination meetings with government actors minimised duplication by ensuring that sites selected for the intervention, including health facilities and schools, were not receiving similar assistance from other NGOs and that their needs could be addressed by the intervention. Successful partnerships with relevant government ministries, departments and agencies were particularly noted in Sierra Leone with DHMT and in Ivory Coast with PNSSU-SAJ. Approaches were developed in coordination and joint implementation was effective due to regular and constant communication, use of shared offices and tools, and flexibility from ACF to respond to government needs.

PROSSAN also worked with partners in each country of implementation, with varying degrees of partnership models. Collaboration with SOLTHIS was effective and the INGO contributed significantly to implementation in Sierra Leone, but there was a lack of effort to maximise synergies. Partnerships with local organisations CAWeC and CAPS in Sierra Leone and CHI in Liberia brought in key technical expertise and community buy-in. Partners are satisfied with their experience and the capacity building they received, but request more holistic engagement in the future. In Ivory Coast, two local partners MESSI and AFJCI were only used to implement a small number of low-budget activities on a contractual basis, missing opportunities to build on their strengths.

Effectiveness

The quality of health services was improved in facilities in Sierra Leone and Ivory Coast through the provision of soft and technical skills and hard materials to health facilities. Skills were developed through trainings on topics of maternal and child health and mental health, and on best care practices such as how to manage and welcome a patient. Mentorship and close supervision further strengthened this learning. Accountability was also reinforced through the use of community feedback groups that created a link between the community and the facility. In Ivory Coast, a series of new digital approaches with a limited scope were successfully used to further enhance care, including digitisation

and a QR code to capture feedback and complaints. In Liberia, no planned activities were done towards this outcome nor on MHPSS as funds were reallocated for COVID-19 response, and were instead used to strength the county health team and ensure health facilities were able to provide services during the pandemic.

Qualitative findings indicate that community-based groups were effective at improving the health knowledge and practices of women and adolescents. Community feedback groups in Ivory Coast and Sierra Leone led on outreach and knowledge sharing within their own communities, further strengthening the link with health facilities. Endline data confirms an increase in women and adolescent girl's contraception prevalence rate in all three countries at the conclusion of the project.

Advocacy efforts were limited during PROSSAN to community-based training and support. However, Ivory Coast was able to develop a series of capitalisation documents at the conclusion of the project, and emphasis on advocacy has been shifted to the next phase.

Efficiency

Lack of human resources at ACF negatively impacted PROSSAN's efficiency. There was a high turnover of technical and implementing staff in each country of implementation, which resulted in loss of organisational knowledge and created gaps in communication and coordination with partners.

PROSSAN also experienced a capacity gap as the project did not have adequate MEAL staff and the project coordinator position was only used at the start and end of the intervention. This forced PROSSAN staff to rely on HQ or non-technical staff, who lacked capacity and direction to ensure adequate monitoring, reporting and coordination.

Lack of information management with all partners and the language difference in the country of implementation reduced opportunities for learning and exchange, which could have increased the intervention's efficiency.

Sustainability

PROSSAN worked closely with national authorities, ensuring that activities were aligned with each country's strategies and implemented with government officials. This approach is critical to transfer ownership of activities to the government, however there is little evidence relevant ministries have the capacity to do so.

Additional challenges include the lack of funding required to continue activities – both IGAs for community-based groups and provision of materials for health staff – and the movement of trained staff and community members into new areas before the target population has changed their health practices.

Ultimately, the program relied on the continuation of activities with PROSSAN 2 and therefore rarely implemented exit strategies.

RECOMMENDATIONS

Management

- Include the program coordinator position throughout the project, or at least during key reporting periods
- Review and enforce the handover process to capture all information not stored in shared folder and to review roles and responsibilities between remaining/new staff to provide clarity for all stakeholders
- Conduct a joint design exercise and validation workshop with partners of PROSSAN 2 to ensure their inputs and priorities are acknowledged and addresses
- Organise a kick off meeting for PROSSAN 2 with all implementing stakeholders. Review indicators and means of verifications for each, with clear roles and responsibilities

Needs

- Review sites selected for PROSSAN 2 with government and partners to ensure priority needs are met and to avoid duplication
- Ensure community needs and priorities are included in PROSSAN 2 activities – review needs identified in evaluation, conduct additional FGDs as needed
- Conduct a study of supply chain to investigate challenges around lack of supplies/drugs and support government to develop action plan
- Narrow focus of intervention in terms of coverage – provide holistic support to less districts to ensure depth of impact

Implementation

Sierra Leone

- Maintain the use of VSLAs and/or IGAs for all community-based groups, and expand to all groups including for youth groups over 18 years old.
- Review activities for PROSSAN 2 to reflect the needs of beneficiaries – there is less need for training and more need for materials/equipment/transportation support
- Shift MSG/FSG into one group with both men and women working together to improve effectiveness of outreach and align with government approach
- Formally engage religious leaders to extend outreach
- Given the success of the AFS, expand the number of spaces or explore options to extend the reach of adolescent activities (ex: use alternative meeting areas outside of health facilities such as markets, schools, water points)
- Identify needs of parents of adolescents and provide training and referrals so they are equipped to support their children
- Provide hard material support to adolescents: support for school fees/textbooks, organising skills trainings

Liberia

- Focus on improving health facilities for targeted communities in PROSSAN 2 to ensure a holistic intervention and avoid sending communities to health facilities that are not equipped to support them

- Review adolescent group activities to ensure they are reflective of the capacities and interest of this age. Either adjust activities to combine with structure such as school/through a new partner, or integrate them as sub group of MSGs until they can move into the separate youth group
- Provide seed funding and (refresher) training to community groups for VSLA/ IGA to promote motivation and group cohesion. Review materials provided for IGA to ensure they are appropriate for the context.
- Review the list of schools targeted for SHC to ensure sustainability, including whether the school is a permanent structure, who owns the land, presence of a guardian counsellor
- Focus government advocacy priorities on improving the infrastructure of health facilities and provide access to services and supplies/commodities
- Include men as beneficiaries of the intervention so they are integrated into MSG and community outreach efforts
- Utilise CHI's rights-based expertise to strengthen the intervention advocacy efforts
- Reintroduce MHPSS awareness and referral activities within community groups and in SHC to address unmet needs due to COVID-19 budget reallocation
- Engage with the MoE to update SHC manual and ensure the inclusion of integrated topics including MHPSS

Ivory Coast

- Review the selection criteria of community representatives for the implementation of the CECom and put in place a process to ensure members are representative of the community
- Reinvigorate mother/father/youth classes and transition skills directly to communities
- Review the materials provided for IGAs to ensure they are appropriate to the context and being utilised effectively
- Advocate with the MHSP to strengthen the institutional recognition of CEComs and the wider federation of CEComs (FECECom)
- Included sensitisation on the cost of services and medication to ensure communities have clarity on what is free and what needs to be paid for when they visit a health centre
- Continue providing supervision and follow up on trainings provided to ensure learning have been integrated by beneficiaries
- Strengthen MHPSS awareness and referral activities at the health and community level to increase access and use of approaches such as the points d'écoute

Partnership

- Hold monthly coordination meetings with all partners to discuss opportunities for joint activities, lessons learned, challenges
- Identify additional opportunities for mutual capacity building between all partners based on their mutual technical expertise
- Review ACF's procurement approach to ensure it is in line with district needs and national standards (Sierra Leone)
- Continue ongoing and constant collaboration with district/county level government at all phases of the project

- Review partnership model to ensure it is aligned with ACF's local partnership project and that collaboration strengthens national organisations
- Conduct due diligence and needs assessment of each partner at the start of the project to identify main capacity gaps and develop an action plan to address them.

Sustainability

- Ensure exit strategy activities are included in the budget to facilitate a smooth transition at the conclusion of each phase of the project
- Conduct joint exit interviews/workshops/assessment with all partners to avoid duplication of efforts
- Include continued monitoring of PROSSAN 1 sites that aren't being included in PROSSAN 2 to capture impact and sustainability (Liberia and Sierra Leone)
- Conduct advocacy to include facilitation in the e-santé application in the scope of work of national health workers (Ivory Coast)
- Utilise medical students (midwives, nurses, doctors) as facilitator for the e-santé application as they can be highly motivated volunteers and are able to relate more easily to adolescents given their age.
- Explore the use of performance-based financing to motivate and keep health staff accountable rather than supplying per diems
- Ensure each activity includes full inclusion of relevant government ministries in design, implementation and monitoring
    - Specifically on informatisation, include DIIS into supervision and monitoring to build on their expertise and transfer ownership
- Provide certificates to community support groups at the conclusion of the project/training cycle

MEAL

- Review proposal indicators to ensure they are relevant to each activity and can be effectively monitored, outlining all means of verification required
- Conduct Knowledge, Attitude and Practices studies to effectively capture changes in target communities' health behaviour
- Launch formal FCM and share with all partner for joint accountability initiative
- Ensure there is adequate MEAL resources to conduct regular monitoring – set clear expectations and review templates and deadlines for monitoring and reporting with all relevant staff

1. INTRODUCTION

1.1. CONTEXT

Despite recent stability following years of violent conflict and epidemics, Ivory Coast, Liberia and Sierra Leone continue to face several crises and shocks that have impacted public services to the detriments of each country's population. National health indicators demonstrate a particular weakness in health services that increase the vulnerability of women, their children and young people. All three countries have high child mortality rates: Sierra Leone has the second highest infant mortality rate in the world and the fourth highest under-five mortality rate while Ivory Coast and Liberia are among the 25 countries with the highest rates[2].

Women are particularly vulnerable during pregnancy and childbirth: all the three countries are among the 12 countries with the highest maternal mortality rates in the world, include Sierra Leone in the 1st place worldwide[3]. Additionally, women in all three countries are also more vulnerable to Sexually Transmitted Infections than men, including higher HIV/AIDS prevalence. Knowledge of HIV transmission and the use of antiretroviral treatment is also low in all three countries. In terms of nutrition, the three countries have also not yet reached the targets set by the World Health Assembly in terms of acute and chronic malnutrition. Ivory Coast, Liberia, and Sierra Leone have global acute malnutrition prevalence rates of 7.6%, 4%, and 5.1%, respectively compared to the <5% target, and high chronic malnutrition prevalence rates of 21.6%, 30%, and 31.3%, respectively compared to the 40% target.

These statistics are reflective of several challenging experiences, including high rates of poverty and unemployment, which directly impact access to health care services. Traditional practices, social norms and lack of education particularly impact women and youth who are excluded from decision-making and therefore unable to change harmful customs. These contribute directly to psychological distress and increase protection risks, particularly gender-based violence such as the excision of young girls.

Finally, all three countries have poor health system performances in regards to key components including leadership and governance, financing, essential medicines, service delivery, health workforce and health information system. According to the Health Services Quality and Access Index (HQA index)[4], Ivory Coast, Liberia and Sierra Leone are among the worst performing health systems in the world. Although the countries have committed to the Abuja Declaration to dedicate 15% of their national budget to health, figures indicate that they are far from meeting those requirements.

The context in which PROSSAN was implemented was also severely impacted by the outbreak of the COVID-19 pandemic. Although the number of recorded cases were lower than expected, the WHO notes that the rate of actual cases detected varies between 3.5% and 45.2% in West Africa, including roughly 40% for Ivory Coast, 8% for Sierra Leone and < 5% in Liberia. In addition to causing fear and mistrust in the health system, the pandemic also led to a series of restrictive administrative measures

[2] Infant mortality in Sierra Leone: < 1 year 92 per 1,000 live births and < 5 years 154 per 1,000 live births. In Liberia, <5 years 78 per 1,000 live births. In Ivory Coast, <5 years 78 per 1,000 live births.

[3] UN Maternal Mortality Estimation Inter-Agency Group - estimates (WHO et al. 2015)

[4] https://www.ncbi.nlm.nih.gov/pubmed/28528753

implemented by each of the three governments, including curfews, confinement, movement restrictions, and the closure of schools/offices.

1.2. OVERVIEW OF THE PROGRAM APPROACH

Given these challenges, the main objective of PROSSAN project is to contribute to improving the health of vulnerable populations in Ivory Coast, Sierra Leone and Liberia through quality health care services adapted to their specific needs. The primary beneficiaries are women of childbearing age, children under 5 and youth, in addition to the staff of targeted health structures. Indirect beneficiaries include populations of the health areas supported by these structures. The project aims to strengthen the quality of and access to health services and to ensure the active participation of communities, particularly women and youth, in national health issues. This is accomplished by strengthening health services and community health workers to provide quality Minimum Health Package (MHP) activities, improving the target population's health care practices and behaviours, particularly around Sexual and Reproductive Health, and the active participation of community management bodies of the health structures and of female and youth civil society in national health issues.

PROSSAN was implemented in three countries through which ACF had varied experience working on strengthening health systems, which determined the scope and activities of each. In Sierra Leone, ACF's relevant former projects include reinforcing the country's institutional capacity to treat acute malnutrition in 2018 and strengthening of IPC in health facilities in 2017. In Liberia, ACF had little experience with health system strengthening and expected PROSSAN to act as a pilot intervention. Conversely, ACF Ivory Coast has been working on health system strengthening since 2014 through two previous projects (MSLS and PARSSI), and PROSSAN was viewed as a continuation of these efforts.

The project targeted health sites, including referral health facilities and district, county or regional level health services in urban and peri-urban areas of Abidjan, Monrovia and Freetown. PROSSAN was led by Action Against Hunger, with a program manager in each mission in charge of the project at the country level and coordination with country partners. PROSSAN was implemented with local partners in each country including SOLTHIS, AFJCI and MESSI in Ivory Coast; CHI in Liberia; and SOLTHIS, CAWeC and CAPS in Sierra Leone.

2. PURPOSE AND SCOPE OF THE EVALUATION

2.1 EVALUATION OBJECTIVE

The evaluation serves to reflect on the performance of the PROSSAN programme (2019-2022), and to identify lessons learned and recommendations for adaptations in the next phase of PROSSAN.

The evaluation was conducted based on the OECD/DAC criteria, in addition to examining cross-cutting issues of gender and youth mainstreaming in key activities. The definitions for each criterion are elaborated below[5]:

[5] Specific evaluation questions for each criteria can be found in Annex 2

- **Relevance:** Assesses whether the intervention is responding to the needs of target populations and the context. It will seek to answer the degree to which the programme objectives and activities have been aligned with the humanitarian needs of target populations (including men, women, girls and boys), local context, national policies and strategies and if it continued to adapt as circumstances changed;
- **Coherence:** Assesses to what extent the interventions are consistent with each other, with existing global and national interventions, policies and structures. It will also assess the strategies that are in place to ensure coherence, maximize synergies and minimize duplication;
- **Efficiency:** Assesses how well resources were used to achieve the results. It will seek to answer the extent to which the intervention activities and results were delivered on time and within budget as compared to alternatives (i.e. efficiently and effectively);
- **Effectiveness:** Judges whether the intervention has achieved its planned results set out in the logframe. It will assess the extent to which the intervention achieved, or is expected to achieve, its results at output and outcome levels, including any difference in results across target groups and geographical areas. It will also identify barriers and contributing factors towards results achieved;
- **Sustainability:** Assesses whether the net benefits of the intervention are likely to continue after the finalisation of programme activities, and how the activities and impact can be built on for a second phase of the project.

In addition to the criteria above, two cross-cutting elements are integrated through each relevant criterion and across the report.

- **Gender and youth mainstreaming**: Assesses the degree to which gender and youth were mainstreamed across activities;
- **Accountability**: Assesses the extent that relevant programme and partner information has been shared with the communities, whether communities were able to participate in all phases of the project cycle (from design up to evaluation processes), the extent that communities were aware and have made use of feedback mechanisms and to what extent PROSSAN staff were able to close the feedback loop.

The proposed evaluation matrix can be found in Annex 2. This matrix includes key and sub-evaluation questions for each criterion, including the integration of both cross-cutting issues throughout.

2.2 USERS OF THE EVALUATION

The evaluation will be a learning opportunity for many different stakeholders. The primary users of the evaluation will be the ACF field teams and partners implementing PROSSAN in Ivory Coast, Liberia and Sierra Leone. The report will also be shared and used by ACF HQ and other country offices worldwide. Secondary users will include the wider ACF network, AFD, and other relevant stakeholders such as donors, national governments, UN agencies, and sector NGOs.

3. METHODOLOGY

3.1 APPROACH

The methodological approach for this evaluation is utilisation focused, participatory and based on mixed-methods. These are defined below:

- **Utilisation-focused assessment:** The assessment conducted for and with specific users. The major considerations in this type of assessment are what the information needs of users are and how they will use the findings. The primary users will be ACF staff in the three implementing countries and their partners, as well as regional and HQ teams.
- **Participatory assessment:** We emphasise participation and collaboration during the assessment process by engaging key stakeholders in the design of the methodology, data collection tools and analysis through regular consultations and opportunities to provide feedback. This allows stakeholders to gain a better understanding of the programme and its assessment, increasing ownership and the probability of these stakeholders using the evaluation findings and recommendations to inform their decisions for future programming. While assuring collaboration with the ACF team at all stages of the assessment process, we will also ensure the affected population is engaged and participation is promoted as much as possible throughout data collection phase.
- **Mixed-methods and triangulation:** We will use multiple data sources and collection methods to corroborate findings and ensure that we obtain a rich, rigorous and comprehensive account against the questions being addressed. We understand that a single method is not adequate to provide a comprehensive picture and therefore using multiple methods and sources helps facilitate deeper understanding.

3.2 DATA COLLECTION TECHNIQUES

Data collection was primarily qualitative and included a literature review of key documents, key informant interviews, and focus group discussions in Sierra Leone and Ivory Coast. Each technique is elaborated on below.

Field visits

Field visits were organised in Sierra Leone and Ivory Coast to conduct in-person data collection. Field visits were primarily oriented to realise FGDs with beneficiaries in the intervention areas, observation of health facilities, and interviews with local implementing and health staff. A member of the evaluation team from the UK conducted data collection in Sierra Leone with the assistance of a translator, while a national consultant led in Ivory Coast. The national consultant was a member of the evaluation team and she had no prior experience with ACF in country or with PROSSAN. At the conclusion of data collection in the field, a presentation of preliminary findings was organised with relevant stakeholders in the country office.

Due to the significantly reduced scope of activities in Liberia compared to the other two countries of intervention, and limitation of time and budget, no field visits were planned in Liberia. Only remote interviews with staff and external stakeholders were conducted.

i. Literature review

The evaluation team analysed secondary documents in order to inform both the design of the evaluation and the findings. Documents reviewed include:

- The final project proposal and NIONG
- Interim reports
- Activity progress reports (APRs)
- Studies developed as part of the project
- Final evaluations of previous projects in the areas of intervention
- MoUs and partnership agreements with local partners
- Capitalisation documents

ii. Key informant interviews

Interviews were conducted with key internal and external stakeholders of the project to gain their perspective on the performance of PROSSAN against the planned objectives and DAC criteria. The evaluation team designed four interview guides for the evaluation. The primary groups targeted were ACF project staff, partner staff, government representatives and health facility staff. Most interviews were conducted remotely via Teams, while interviews with Sierra Leone and Ivory Coast were conducted in-person when possible.

A breakdown of these interviews can be found in the table below.

Table 1: Key informant interviews conducted

	Sierra Leone	Liberia	Ivory Coast	Total
HQ	-	-	-	2
Regional	-	-	-	2
Program staff	3	2	3	8
Partner staff	4	1	2	7
Government	7	1	6	13
Health staff	6	1	10	16
Beneficiaries	3	1	6	9
Total	**23**	**6**	**27**	**60**

iii. Focus group discussions

Focus group discussions were used to gain insight into the experience of the target beneficiaries of the project in each country. They gathered feedback especially on the relevance, effectiveness, coverage, impact and sustainability of the project as well as the quality of the accountability to affected populations.

FGDs were conducted in Sierra Leone by a member of the evaluation team and a translator, while those in Ivory Coast were conducted by a national consultant. The FGD

guide was developed based around key elements of the evaluation and was adapted based on context. The guide is included in Annex 5.

The overarching principle for the sample selection was to include the primary target groups of the project. This includes direct beneficiaries of the project activities aimed at improving health practices and behaviours, and enhancing community-based rights approaches. FGD locations were selected to ensure representation from the various types of health facilities, catchment area sizes, geographical location (ex: slum/rural). FGD participants were selected based on the nature of activities being evaluated. Gender segregation was maintained throughout all FGD, and just over half of the participants were female (56%). Representation of different age groups was also ensured through purposive sampling of adults (39%) and youth (61%). The specific breakdown of the sample, by activity and location is outlined in the table below.

Table 2: Focus group discussion participants

Country	Location	Beneficiary Characteristics	# of participants
Sierra Leone	Kissi Town	Adolescent girls (15-19), users of Adolescent Friendly Spaces (AFS)	13
		Adolescent boys (15-19), users of AFS	9
	Susan's Bay	Adolescent girls (10-14), users of AFS and SHC	12
		Adolescent boys (10-14), users of AFS and SHC	10
	Kroobay	Adult women, FMC and MSG members	8
		Adult men, FMC and FSG members	7
	Campbell Town	Adult women, FMC and MSG members	8
		Adult men, FMC and FSG members	9
Ivory Coast	Anono	Adolescent girls, e-santé/AFS/youth class users	7
		Adolescent boys, e-santé/AFS/youth class users	7
	Gonzagueville	Adult women, CECom members and class participants	6
		Adolescent boys, e-santé/AFS/youth class users	5

		Adolescent girls, e-santé/AFS/youth class users	5
	Adiopodoume	Adult women, class participants	6
		Adult men, class participants	4
		Adolescent girls, AFS/youth class users	4
		Adolescent boys, e-santé/AFS/youth class users	4
		Total	**124**

At the inception stage, eight focus groups were planned with four in Ivory Coast and Sierra Leone respectively. However, the number of FGDs was doubled during data collection, as shown in the table below. In Ivory Coast, adjustments had to be made during the field visit based on the availability of beneficiaries given that some community-based activities had been completed several months prior. As a result, although a field visit was conducted in Abobo Baoule, no FGD with target beneficiaries was conducted at that location. Additional discussions were therefore scheduled in the other locations visited.

Table 3: Actual vs Planned FGDs

Participant category	FGDs in Sierra Leone		FGDs in Ivory Coast		Actual Total
	Planned	Actual	Planned	Actual	
Adult women	1	2	1	2	4
Adult men	1	2	1	1	3
Adolescent girls / youth	1	2	1	3	5
Adolescent girls / youth	1	2	1	3	5
Total	**4**	**8**	**4**	**9**	**17**

iv. Observations from field visits

In addition to getting insights from various relevant stakeholders in the PROSSAN project, observations of health facilities were conducted during field visits in each location using predefined checklists. A total of 8 observation checklists were completed at each of the sites selected for FGD outlined above – 4 in Sierra Leone and 4 in Ivory Coast – in addition to Abobo Baoule in Ivory Coast.

v. Qualitative questionnaires with indirect beneficiaries

In order to capture the perceptions of wider community within the catchment area of the health facilities included in the project, indirect beneficiaries were surveyed at the exit of health facilities in Sierra Leone. Exclusion criteria included any individuals who were direct beneficiaries of PROSSAN including members of the FMC or MSG. Individuals were asked a short series of questions to examine their satisfaction and experience with the health system and the services they received. The questionnaire guide is available in Annex 6.

Data collection was conducted by the ACF Sierra Leone MEAL staff during field visits for the endline assessment of PROSSAN 1 and shared with the evaluation team. Given endline data collection had already been completed in Ivory Coast, and due to time and coordination constraints, questionnaires were only administered in Sierra Leone.

3.3 DATA ANALYSIS

Based on the evaluation questions, a thematic analytical framework structured according to key topics and emerging areas was developed. The thematic framework guiding the qualitative analysis remained flexible and was adapted during the assessment. The NVivo programme was used to assist the qualitative research. Methods triangulation was used, which means validating the consistency of findings generated across different data collection methods, and data source triangulation, by gathering information through consultations with different stakeholders.

Key lessons and best practices were extracted from the FGDs and interviews looking for recurrent themes or patterns as well as exceptional stories or evidence in order to explain the data or explore it further. These were used to identify areas of learning and recommendations for the next phase of PROSSAN.

Following the analysis of primary and secondary data, a RAG (Red-Orange-Amber) rating was given for each evaluation criteria. More details can be found in Annex 1.

4. LIMITATIONS

Poor documentation: as identified during the evaluation, the project faced significant MEAL and reporting challenges that prevented appropriate monitoring and reporting. This resulted in limited access to documents to assess the performance of the project and identification of lessons learned. Additionally, quantitative monitoring data was not consistently reliable as findings from the interim report and activity progress reports did not always align, thereby reducing opportunities to integrate quantitative analysis and triangulation into the evaluation.

Timing of the evaluation: the evaluation was conducted in parallel to the endline studies, so there was a significant lack of quantitative data on the effectiveness of the project to analyse and use for triangulation. Efforts were made to use the most updated results framework provided by ACF staff and to rely on monitoring data to mitigate this challenge during analysis. Nonetheless, many findings are primary qualitative in nature as a result of this gap.

Access to personnel: high level of staff turnover at ACF resulted in few KIIs conducted with individuals involved at the design and start of the project. This has included new Country Directors and changes in program managers in each country of implementation, a new project coordinator at the end of the project and two new Nutrition Head of

Department in Sierra Leone and Ivory Coast. As a result, there is less evidence and perspective on the performance of the project from inception. This was mitigated by triangulating the information received with secondary documentation where possible.

Limited data collection in Liberia: Given the reduced scope of activities in Liberia and limited time and budget, no in-person data collection was done in Liberia. Additionally, challenges to schedule key informant interviews with government and health staff have resulted in a gap of information. This was mitigated by triangulating data through staff interviews and monitoring documentation where possible.

5. ETHICS AND DATA QUALITY

5.1 ETHICS AND SAFEGUARDING

We have adhered to the following ethical principles whilst undertaking this assignment:

- Do no harm (physical, emotional, sexual): To anyone with whom we come into contact during assignment.
- Informed consent and confidentiality: All our team members read out the informed consent instructions for each of the research tools and recorded verbal consent from all participants. All names will be anonymised to ensure respondent confidentiality.
- Impartiality: No risk of discrimination against anyone involved on the basis of sex, religion, language, ethnicity, sexuality or any other grounds.
- Data security: Relevant protocols are in place to ensure that the data is secure in line with GDPR compliance requirements.
- Professional standards: Maintained professional boundaries at all times and collected and checked data so that it is accurate and of highest quality. Wealigned our behaviour with Action Against Hunger Internationals Principles of; independence, neutrality, non-discrimination, free and direct access to people in need, professionalism and transparency.

5.2 QUALITY ASSURANCE

The Team Leader, Federico Ercolano, has overall responsibility and is accountable for delivering this contract including review of all deliverables before submitting, technical direction and support. We ensure that deliverables are produced on time, within budget and to the desired quality; staff are kept safe and secure; and client data is protected. To ensure the quality of the assessment products the team will:

- Hold regular internal project management meetings to track delivery and quality, deal with problems as they arise;
- Compile and document in the project files relevant information (including meeting minutes, work plans and deadlines, programme documentation and relevant reports);
- Maintain clear and open communication with Action Against Hunger and other relevant teams at all times;
- Seek feedback from the client and incorporate all feedback into design, process and outputs; and
- Conduct an internal evaluation team review of all deliverables, including internal quality assurance Action Against Hunger UK has proposed a team that is highly respected in their field and will ensure high quality products.

We ensure that all team members are adequately trained on data collection and will undertake remote checks in order to ensure collection of reliable and quality data. As part of our team we have in-country consultant to support and oversee data quality. In addition, we refined and piloted the data collection tools with Action Against Hunger France, to ensure suitability and greater quality of data.

6. FINDINGS

In order to calculate PROSSAN performance as a whole, a weighted score was assigned to each country of implementation based on a selection of criteria defined by Action Against Hunger France. The criteria, score and weighted average is outlined in the table below.

Table 4: Weighted average of each implementation country

Criteria	Sierra Leone	Liberia	Ivory Coast
Budget	50%	15%	35%
Number of partners	43%	14%	43%
Number of health facilities	49%	13%	38%
Reproductive health programmes (including partners)	53%	21%	26%
Average	**49%**	**16%**	**36%**

As a result, the following table indicates PROSSAN's performance against the evaluation criteria. Each criteria is further examined in the following section.

Table 5: Performance by evaluation criteria

CRITERIA	RATING (1 poor, 5 high)					JUSTIFICATION
	1	2	3	4	5	
Relevance				4		Activities were aligned to government priorities and relevant to beneficiary's needs, with some gaps.
Coherence			3.7			Close collaboration with government and local partners leveraged their strengths, but the partnership model was a mixed success.
Effectiveness			3.3			Community-based support groups and engagement of adolescents was mostly successful to improve health practices, but reallocation of funding for COVID-19 limited implementation in health facilities and cut many MHPSS activities.
Efficiency		2				Challenges with staff turnover, weak MEAL approaches and poor information management impaired the project's efficiency.
Sustainability			3.5			Government integration and beneficiaries' commitment to continuing activities beyond the

						project enable sustainability, but lack of resources and local integration remain a challenge.

6.1 RELEVANCE

Table 6: Performance of Relevance criteria

COUNTRY	RATING	JUSTIFICATION
Sierra Leone	4. Meets expectations	Majority of activities are relevant to government and community needs. Alignment with government priorities is ensured throughout but limited engagement with communities at the design stage resulted in some gaps.
Liberia	4. Meets expectations	Activities implemented at the community and school level are in line with MoE standards and are relevant to needs of target communities, although some priorities have not been addressed.
Ivory Coast	4. Meets expectations	Activities were implemented in partnership with the MSHP, ensuring they stuck to national priorities. Community support addressed needs but several gaps were identified by youth and health staff.

GOVERNMENT POLICIES AND PRIORITIES

Evidence demonstrates that the PROSSAN project was extremely well aligned with government priorities in Sierra Leone, Liberia and Ivory Coast. Interviews with staff and government officials indicate that the project's objectives and activities reflected national strategies on maternal and child health, nutrition, malnutrition reduction, and adolescents and were able to address some of the countries' biggest health challenges.

In SIERRA LEONE, PROSSAN activities fed into the *Reproductive, Maternal, Neonatal, Child and Adolescent Health Strategy*, the *National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage* and the *Multi-Sector Strategic Plan to Reduce Malnutrition in Sierra Leone*. This was in part due to the project being designed and implemented in close collaboration with the Ministry of Health and Sanitation (MoHS). For example, the District Health Management Teams (DHMT) reviewed and adjusted the targeted facilities based on the district's needs, jointly led on the supervision of PHUs, and received regular reporting from ACF. All stakeholders interviewed for the evaluation felt the activities in Sierra Leone were harmonised with government policies, however some members of DHMT noted that there should be a shift in focus away from training towards the provision of materials and funds required to implement on their new knowledge. Although health staff requested continued training, they also echoed the dire need for material support to their facilities. Close monitoring and the use of performance-based financing could provide the appropriate materials and incentive to ensure quality of implementation while aligning to government needs.

PROSSAN's MHPSS activities contributed to the *National Mental Health Policy 2018-2027*, and ACF is one of the MoHS's key stakeholders to advance the MHPSS agenda in Sierra Leone. MoHS and DHMT staff noted that MHPSS activities are a priority given the country's history with trauma, including wars, Ebola and natural disasters. ACF has provided drafting and advocacy support to develop the Lunacy Act. ACF is a member of the mental health steering committee, which enables PROSSAN activities to be aligned with the needs of the MoHS. Health facility staff received training on the mhGAP, and noted improvements on their ability to understand mental illness and treatment.

The project was closely aligned on nutrition and youth health objectives in **LIBERIA**, but faced challenges around SRH as the national policy expired last year. Staff worked with the MoH to develop Mother Support Groups (MSGs) as indicated by the Nutrition Division's agenda and associated activities with the efforts of the country health staff. ACF also consulted with the Family Health Division and the county and district teams at the start of the project to receive materials for trainings. On SRH, ACF staff consulted the MoH's Family Health Division to receive materials for trainings, but may not have been based on current needs given the lack of updated policies. ACF also held a kick off meeting with the county and health staff, but SRH activities were not ultimately implemented due to reallocation of funds for COVID-19. One KII noted that communication between the different levels of the MoH is always effective and therefore requires additional capacity from ACF staff to ensure all stakeholders at the district, county and national level are regularly updated and consulted. PROSSAN also engaged closely with the Ministry of Education's School Health Division to implement the School Health Clubs (SHCs), contributing directly to the Liberian government's priorities for youth. ACF staff was trained by the central office on the SHC manual and approach, and all schools selected were validated by the SHC. As a result, the formation of all SHCS and their activities fed into the government's priorities, contributing the resources needed to provide the services for adolescents. Although ACF has identified mental health as a priority for adolescents despite it being outside of the scope of the SHC manual, reallocation of budgets for COVID-19 resulted in MHPSS activities not being implemented.

In **IVORY COAST**, PROSSAN was implemented closely with the MSHP and aligned with the National Health Development Plan 2016-2020 and the National Multisectoral Nutrition and Early Childhood Development Program which both aim to reduce maternal mortality. Government officials noted that activities fed directly to the MSHP's strategic goals to improve malnutrition prevention through exclusive breastfeeding and IYCF. One member of the PNSSU-SAJ noted that working with adolescents is a priority for the future of Ivory Coast as well as the need to regulate birth rates. Activities in health facilities were done in conjunction with district staff, including for trainings and monitoring.

Ivory Coast lacks an adolescent mental health policy, and as a result the MSHP does not actively use psychosocial spaces in their approaches. Nonetheless, PROSSAN worked closely with the Mental Health National Program staff to identify gaps, provide trainings for health staff and develop new tools to reach adolescents. The success of the project highlighted the relevance of PROSSAN's activities, which the government now plans to scale up at a national level. Digitization is also a priority of the MHSP with an aim to reduce the use of paper across Ivory Coast. However, DIIS acknowledge that this is an extremely slow process due to administrative delays and is currently only focused at the top of the sanitation pyramid – so PROSSAN's efforts at the bottom of the pyramid working directly with health facilities are welcome.

Despite this close collaboration, government officials in both Sierra Leone and Ivory Coast requested to be consulted during the design phase, specifically noting for

PROSSAN 2 that we wanted to support the draft of the proposal so it focuses on their current priorities and needs.

TARGET POPULATIONS

PROSSAN activities responded to most of the primary needs of the target population across the three countries. These needs are vast, including high maternal mortality, malnutrition and MHPSS challenges of adolescents. However, there is little evidence that beneficiaries were consulted during the design phase about their specific needs nor that a needs assessment was conducted in any of the implementing countries, with the exception of the participatory baseline assessment led by SOLTHIS in health facilities in Sierra Leone. As detailed below, some stakeholders felt that the support provided was not entirely reflective of the needs of the community.

FGDs with community beneficiaries and interviews with health staff in **SIERRA LEONE** demonstrate that the trainings received were on topics relevant to the community's main difficulties. These included family planning, exclusive breastfeeding, and coping mechanisms – further topics are explored in the effectiveness section below. Regarding HIV, SOLTHIS conducted a participatory needs assessment to identify gaps in service provision and developed a road map based on these needs. Staff noted that the trainings received by SOLTHIS, ACF and DHMT allowed them to address gaps in their own abilities and competencies. For example, staff have improved their documentation skills and their ability to register and monitor patients using clear charting systems. The SOLTHIS endline demonstrates that 56% of supported sites scored above 60% on ART quality of care score, indicating an important improvement in charting, testing and referrals.

Beneficiaries also noted related needs that were not being addressed by the project. For members of MSGs, FSGs and FMCs, this was linked to materials required to do outreach effectively, including visibility items such as ID cards or t-shirts, and rain boots. This would allow them to engage their communities with authority and credibility, while rain boots are key to access remote areas during the rainy season. For health staff, this was around the lack of supplies in PHUs including equipment and drugs.

PROSSAN addressed key challenges in **LIBERIA**, but communities often identified different and more pressure problems around WASH and infrastructure that were outside of the project's scope. As a result, field staff attempted to link communities with other NGOs working in the area in those sectors, but the mismatch of expectations between the project and the community was a hinderance. Although PROSSAN was able to provide infrastructure support in Ivory Coast and Sierra Leone, the scope of activities did not permit the same in Liberia. There was no evidence that ACF coordinated with NGOs in a systematic way to aim to mitigate this challenge, such as participation in clusters.

As in Sierra Leone, mother support groups in Liberia were trained on topics including personal hygiene, breastfeeding practices and better nutrition. A lead mother noted that this support helped the community a lot and that changes, particularly for teenagers, was evident. She also shared the request for more material support to the community group, including rain gear to continue outreach during the rainy season, and visibility items such as t-shirts to ensure they have the respect of the community and a link to ACF. Health staff noted that communities also needed MHPSS training to enable referrals to facilities, as community members who are mentally unstable often become depressed or resort to suicide.

Capacity building of health facilities, including on MHPSS, and improvement to the quality of care was not achieved due to reallocation of budget in response to COVID-19.

However, community-based activities continued and encouraged an increased attendance to health facilities regardless of this gap. As a result, there was an increase in demand and expectations from community members that was not met by health staff who faced the same challenges identified at the start of the project around lack of supplies, poor capacity and lack of knowledge. Although there was no budget for SRH activities, ACF attempted to continue monitoring efforts of health facilities but faced challenges as they were no longer providing any activities or support, leading to health staff frustration.

Beneficiaries in IVORY COAST indicated that PROSSAN responded to key needs, particularly targeting youth and through the use of CEComs. Young people noted they had been consulted by ACF in 2019 to understand the challenges faced by young people, and had subsequently received training on SRH, such as learning information on STIs and how to access contraception. However, they also felt that drug and alcohol abuse and prostitution were not discussed enough in the AFS or classes. These are sensitive issues faced by many young people that are difficult to address with family, and respondents want more outreach into the community and schools to engage more youth affected by these challenges and make them aware of the counselling and support. The PNSME coordinator noted that the lack of national data available on adolescents and their needs resulted in activities that were certainly useful but perhaps not reflective of their priorities.

Across all three countries of implementation, PROSSAN lacked a formal feedback and complaints mechanism. Rather, community feedback groups including FMC and CECom fostered feedback between communities and health facilities, and suggestion boxes were used in most sites with mixed results. In Ivory Coast, the use of the e-santé application and the QR code pilot created additional opportunities for community members to communicate any feedback confidentially, but the scope of these approaches was limited. Although staff and community members indicate that there was open communication in the field and that minor feedback was shared, the minimal FCM indicates an important accountability gaps, preventing PROSSAN from safeguarding its beneficiaries and responding to their needs.

Overall, the project would benefit from a review of the selected sites with both government and partner stakeholders to ensure local needs are being met. Partners in Sierra Leone and PNN staff in Ivory Coast specifically noted they would have wanted to be consulted based on their expertise of existing gaps. Validation of activities and of the materials provided should be conducted with local communities. Given the lack of supplies and drugs in all three countries, advocacy efforts should focus on addressing this challenge. ACF can conduct a study of the supply chain to investigate the specific challenges and support the government to develop an action plan.

SUMMARY: PROSSAN is highly relevant to the priorities and policies of the government in each country of intervention, addressing critical national needs around maternal and child health. The project was designed and implemented in close collaboration with government staff, assuring this relevance. PROSSAN is primarily aligned with the biggest needs of target communities, with some minor gaps. This is partially due to the project's reliance on district/county government's needs assessment and lack of direct engagement with beneficiaries during the design phase.

6.2 COHERENCE

Table 7: Performance of Coherence criteria

COUNTRY	RATING	JUSTIFICATION
Sierra Leone	4. Meets expectations	Close coordination and joint implementation with DHMT and local partners ensured coherence of activities. There remain some areas of improvement to ensure collaboration is more effective and maximises opportunities for synergies.
Liberia	4. Meets expectations	Engagement and collaboration with the MoH and MoE and with local partner CHI enabled effective implementation. Nonetheless, additional opportunities to build on CHI's rights-based feminist approach were not pursued due to budget limitations.
Ivory Coast	3. Overall, meets expectations	A strong relationship and joint implementation with the MSHP contributed to effective coordination and harmonisation of approaches. However, the mission's limited use of local partners as contractors rather than collaborators prevented broader complementarity and sharing of experiences.

GOVERNMENT COLLABORATION

As noted in the Relevance section above, PROSSAN program staff worked closely with government officials to implement activities in all countries of intervention. This ensured the intervention was consistent with existing efforts and minimised duplications.

In SIERRA LEONE, all activities at the health facilities were conducted jointly with DHMT staff, including the selection of training topics based on the development of new policies and gaps identified by district health teams such as on EmONC. Staff from the MoHS and DHMT were very happy with the partnership with ACF. Constant communication and the use of the same tools, indicators and policies enabled DHMT to remain abreast and focused on the project. The MoHS hosted monthly coordination meetings with NGOs working in the sector that were attended by ACF and partner staff. They also led quarterly meetings to review each organisation's workplans. These coordination meetings reduced the duplication of activities as each NGO was directly to intervene in specific centres based on existing needs and gaps.

ACF also coordinated closely with the MoHS's mental health division to increase mental health awareness and improve health staff ability to treat mental illness. The ministry's MHPSS focal point shared that any mental health activities are identified by ACF and validated by the MoHS who then support on implementation and to lead trainings on the mhGAP for staff. ACF work closely with the MoHS to offer trainings and counselling to reduce stigma, particularly around sensitive topics including HIV and COVID-19. However, community-based MHPSS activities did see the same level of engagement with the MoHS, aligning with policies but led by PROSSAN partners with less direct support from the ministry.

Activities related to school health club (SHCs) in LIBERIA were delivered with and through the School Health Division of the MoE. Schools were identified and selected in collaboration with the MoE at the design stage so clubs were only launched in government-run institutions. The MoE provided training to ACF staff on the SHC manual to ensure activities and the launch of the clubs was aligned with the government approach. ACF then provided training and supervision to the local guardian counsellors who are government employees but based in the schools, in order to enhance their ability to facilitate SHC and support students and ensure they are able to take full responsibility of the clubs' activities. As per the MoE guidelines, the goal of the SHC is to build the capacity of students and staff to run health initiatives and to enable behaviour change through awareness campaigns. The MoE noted that ACF completed the efforts of the ministry, and that the project was embraced as PROSSAN aligned so well with the government's strategic goals of ensuring student's health and wellbeing.

Activities in IVORY COAST were very closely delivered with the MSHP, in particular with the PNSSU-SAJ. The country office's previous experience working on health system strengthening contributed to positive and effective relationships with the government. A major success of the program was its close collaboration with the PNSSU-SAJ, including sharing an office. Government staff were pleased with the tight partnership with ACF and regular communication which promoted effective collaboration and joint implementation. One key informant specifically noted that ACF's flexibility in the face of government bureaucracy was particularly appreciated and allowed for the project to move forward at critical junctures. For example, ACF was able to increase its budget for the launch of the e-santé application following discussions with the PNSSU-SAJ on the need to host a larger event to ensure ministerial presents and buy-in. Staff from the National Mother and Child Health Program (PNSME) shared that despite slow start due to bureaucracy and the need for approval from the whole ministry, the partnership with ACF went well for any activities that fit into the program's priorities.

Furthermore, a key informant from the National Mental Health Program (PNSM) also noted a strong collaboration with ACF that was harmonised and allowed both partners to adjust and address problems as they arose, and to offer mutual support that led to a new approach for the program of working within school health.

Staff from the National Nutrition Program (PNN) similar felt collaboration through group work and regular consultation and PROSSAN's alignment with country protocols were effective. However, they also noted that they would have liked to be involved in the design of the project and for ACF to shift more responsibilities to partners rather than being the main implementor.

Poor collaboration was noted by the DIIS, who were not engaged in monitoring of activities. Although the department supported the design and launch of the digitization process, DIIS was not included in supervision. This reduced both government ownership and opportunities for learning from DIIS' experience of digitizing systems across Ivory Coast. Efforts were made to integrate DIIS at the conclusion of the project through a joint supervision, but it did not occur as planned due to lack of availability.

PARTNERSHIPS

Implementation of PROSSAN activities was completed in partnership with both international and local organisations. ACF utilised varying levels of partnership across Sierra Leone, Liberia and Ivory Coast with equally varying levels of success.

ACF worked closely with SOLTHIS, another French international NGO with expertise in the strengthening of health systems with a focus on HIV that made it a natural partner

for PROSSAN. This partnership was led at the HQ level and was implemented in both Sierra Leone and Ivory Coast. In the former, SOLTHIS staff operated directly in health facilities to improve staff's capacity on HIV treatment. In Ivory Coast, the organisation provided technical expertise through two field missions to provide trainings on HIV sensitisation. SOLTHIS worked with the MHSP as national partners, who in terms were able to train health staff involved in the PROSSAN project on HIV care. who could then train PROSSAN health staff on HIV sensitisation.

In both countries where SOLTHIS worked on PROSSAN, staff from both organisations felt that coordination between SOLTHIS and ACF was limiting and missed opportunities for a deeper relationship. SOLTHIS expertise was not utilised to their full potential to enhance ACF nor local partners' capacities. ACF staff at the regional and HQ level shared these concerns, noting they were caused by the lack of ACF staff capacity and coordination, including the lack of a national steering committee. For example, there was a missed opportunity for synergy between SOLTHIS and ACF when the former conducted its endline assessment of health facilities. As a result, ACF conducted their own data collection for their endline and evaluation that required repeat visits and questions to health facilities.

In SIERRA LEONE, partnerships with local organisations with CAWeC and CAPS were successful and enabled PROSSAN to build on their technical expertise to strengthen the intervention. Capacity assessments were conducted with both partners at the start of the project to understand their expertise and potential gaps. CAWeC's experience in the community allowed them to lead on the formation of mother and father support groups for behavioural change. CAWeC's office is right next to the ACF office, enabling them to receive closer capacity building support across all support services. CAPS focused on MHPSS, training community members and community health workers on Psychological First Aid and facilitating AFS. reported satisfaction with the overall partnership, but also requested to shift the relationship into "a real partnership" based on collaboration rather than contractual activities. Overall, all partners felt there were minimal opportunities for all organisations to come together to meet and engage each other. Although regular communication between ACF and each respective partner was successful, the lack of regular monthly meetings was limiting, and staff request the project move towards a consortium model that promotes greater access and equity between partners.

CHI was the only implementing partner in LIBERIA, providing community buy-in and expertise with women, SRH and GBV. A capacity assessment was conducted at the start of the project to identify CHI's gaps and areas of needs as part of ACF's partnership model. As a result, ACF providing capacity building to CHI on Maternal Infant and Young Child Feeding interventions in the community and provided both mentoring and field supervision during the formation of MSGs. Nonetheless, staff turnover and lack of co-financing limited ACF's funding and internal capacity to address all of the gaps identified in the assessment. Combined with the lack of focal point for the partner at ACF, CHI faced some due-diligence challenges that slowed down monitoring and reporting. Furthermore, CHI expressed frustration that the organisation was not viewed as an equal partner and that its input was not reflected in project adjustments. Nonetheless, both ACF and CHI staff report a successful implementing partnership with constant communication.

The partnership model in IVORY COAST was the most basic among all three countries as it used local partners for implementation only rather than allowing for capacity building or strengthening of local structures. Despite signing cooperation agreement that indicated long-term partnership, the two local organisations who participated in PROSSAN, MESSI and AJFCI, were provided with small budgets and had to work with ToRs for each activity implemented. This micro-management restricted partner's ability

to plan and adjust based on communities' medium to long term needs, and prevented the effective capitalisation on their own technical expertise.

Overall, efforts should be made to further develop the relationship with ACF's partners across each country of implementation into a partnership that support mutual capacity building and strengthening. This should be done through a review of each partner's contract agreement and a full needs assessment to identify gaps and priorities. A validation workshop and kick off meeting of PROSSAN 2 should be organised with all partners to ensure each organisation's input and interests are considered, and to review all activities and indicators to ensure clarity on roles and responsibilities.

SUMMARY: PROSSAN coordinated closely with governments to ensure coherence and to exploit opportunities for synergies. Partnerships with local organisations also allowed the project to bring in expertise outside of ACF's focus and provide a larger platform for smaller NGOs. However, ACF's use of partnerships for the project was a mixed success, as country teams invested varying amount of budget and capacity building for their local partners. Staff turnover at ACF also had a negative impact on partners in Sierra Leone and Ivory Coast.

6.3 EFFECTIVENESS

Table 8: Performance of Effectiveness criteria

COUNTRY	RATING	JUSTIFICATION
Sierra Leone	4. Meets expectations	Support to health facilities and the formation of community-based groups improved health practices for communities. Areas of improvement, particularly around advocacy, remain.
Liberia	2. Needs improvement	Community-based groups were effectively implemented, while school health clubs were partially implemented without MHPSS activities, but the lack of activities to support health facilities did not allow the project to meet its objectives.
Ivory Coast	3. Overall, meets expectations	Quality of health services were improved through support to health facilities and the use of innovative digital technologies. Community-based groups were effective but struggled to keep traction.

The overall objective of the PROSSAN project is to improve the health of vulnerable populations in Ivory Coast, Sierra Leone and Liberia by providing quality care adapted to their specific needs. Generally, PROSSAN was able to achieve most its targets for each outcome, with the major exception of outcome 2 in Liberia due to the reallocation of budget from these activities to COVID-19 response efforts.

Across the three countries of implementation, activities and outcome indicators varied slightly but shared common approaches and outcomes. A simplified logical framework

outlining the project's objectives and outcomes is below, and a full framework including indicators and results is available in Annex 9.

Table 9: Simplified logical framework

Global objective	To improve the health of vulnerable populations in Côte d'Ivoire, Sierra Leone and Liberia, particularly women, children under five years of age and adolescents, by providing quality care adapted to their specific needs.
Specific objective	Strengthen the quality of and access to health services and ensure the active participation of civil society and community actors, especially women and youth, in national health issues.
Expected Outcome 1	Health services and community health workers provide quality activities and services in accordance with Ministries of Health Minimum Health Package (MHP) standards.
Expected Outcome 2	The target populations, particularly women and adolescents, improve their health-related practices and behaviours.
Expected Outcome 3	The active participation of community management bodies of health facilities and of women and youth civil society in health issues is ensured at national and decentralised levels

Generally, staff in each country felt that the scope of the project was too large and aimed to accomplish too many different outcomes with a limited budget and staff. The geographical coverage of activities put a strain on staff's time and resources.

The following section reviews PROSSAN's performance against its expected outcomes, and includes a series of focus boxes to highlight some of the innovative approaches utilised by the project.

QUALITY OF HEALTH SERVICES

Health services improved in Sierra Leone and Ivory Coast through capacity building activities and material support – enhancing the care provided by staff and the community's perception of it. Equivalent activities were not implemented in Liberia due to budget reassignment in response to COVID-19.

In SIERRA LEONE, health workers reported a significant improvement in technical knowledge and skills of facility staff and CHWs on the project's key issue areas, and a resultant improvement of care. Health staff participated in trainings, refresher training, supervision and mentorship to increase their capacity – both on the standards of delivery of care and on the technical specifications for their roles. Interviewed HIV focal points specifically note that the close mentorship and supervision they received from SOLTHIS allowed the wider staff of the health facility to radically transform the care provided, from registration, treatment and confidentiality.

The mhGAP training received by health staff has significantly improved the referral link between the health facility and the specialised hospital. Staff indicate they are now able to counsel patients who may have a mental illness and provide appropriate treatment.

SOLTHIS' ART Quality of Care Score

SOLTHIS devised a methodology to measure improvement to the quality of care of supported health facilities. The methodology is based on weighted pre-defined sub-indicators. SOLTHIS' extensive methodology and ToR is an example of effective monitoring efforts (see Annex 10).

Lack of joint monitoring and close collaboration between ACF and SOLTHIS did not enable the use of the methodology by other implementing partners. However, the approach is easily adaptable and can be deployed to assess other PROSSAN sites to ensure a robust monitoring of the project's intervention.

The quality of care score report conducted by SOLTHIS at the end of the project indicated a significant improvement of Adult HIV treatment care in all supported sites. The improvement in the quality of care increased health worker's motivation and evident changes such as longer hours and friendliness of staff also increased communities' confidence. This confidence was evidenced by an increase in PLW visits, and additional communities outside of a facilities' catchment area now traveling to visit those with strong reputations. Feedback from users of the facilities indicate that 95% felt respected by health staff in regards to dignity, confidentiality and wait time – an increase from 60% at the interim stage of the project. Facility Management Committees were launched in the 22 supported health facilities in Sierra Leone to create a channel between the community and the health staff. Committees were made up community leaders and health staff members, holding monthly meetings to address complaints brought up by patients and create action plans to resolve the facility's challenges. FCM members view themselves as a critical advocate for their community, with one member noting "we see ourselves no longer as the masters but as the servants of the people, that is why we do outreach". Health staff also reported that these committees allowed for an easier flow of feedback from the community and an improvement in relations between the two groups.

Health facilities in IVORY COAST received consistent support to improve care, including on infrastructure (boreholes, latrines) and the provision of materials (beds, equipment, computers). Digitization of sites through the provision of computers and training was a partial success. Health staff report that computers often didn't work due to electricity cuts and use of computers slowed down consultations as staff uses paper and then computer registers. The computer at the cash register was viewed as a useful tool, but with requests for further training. Other challenges of digitization include the

Digitization

In Ivory Coast, PROSSAN worked closely with the MHSP and the DIIS to support the government's efforts to digitise health documentations across the country. Computerisation would ensure continuity of patient records, access to data at the national level, reduction of paper and increased analytics (see Annex 11 for more details).

PROSSAN provided computers and trainings to health facilities to facilitate the transition to digital, but faced challenges. Staff working directly with patients, including nurses and caregivers, were reluctant to take up the new approach as it was more time consuming and slowed down consultations. HOSPI-SOFT, the software introduced by ACF did not completely align with the government system and created additional work.

Current government resources are focused on digitising at the ministerial level. ACF is providing support to local health facilities, but greater resources are required to scale up the initiative. Without a country-wide effort, the benefits of digitisation are limited and risk alienating staff who currently feel it is not a useful tool.

misalignment of the software implemented by ACF with the national standards (for example, on the input of age ranges), and the cost and lack of internet at many sites.

Health staff also received training and supervision to improve governance and provision of care. For example, 10 sites were supported to receive certifications for the Baby Friendly Health Facilities Initiative[6] (ISSAB), enabling staff to gain more knowledge on exclusive breastfeeding. Participants note an increased confidence in being able to promote exclusive breastfeeding to mothers, and centres saw an important improvement in breastfeeding rates. Monthly monitoring of health facilities also indicates a decrease in the dropout rate for antenatal visits in Ivory Coast from 52% at baseline to 23% at the end of the project.

Staff also received training on MHPSS from ACF in coordination with the PNSM. This focused particularly on providing support to adolescents who have historically received poor welcome and treatment by health staff. Health staff indicate feeling better equipped to understand the challenges faced by youth, and the PNSM coordinator felt there has been an important shift in tolerance and reduction in discrimination. Nonetheless, the lack of integration of MHPSS training for staff working on nutrition or MCH was noted as a gap in improvement of quality of care.

Overall, the supervision provided by ACF to health staff was critical, with some district health staff noting that the mere presence of ACF motivated staff to follow best practices and reassures them on the quality of their work. Following joint supervision, these responsibilities have now transition fully to the district, and health staff have indicated that they do not feel they are now receiving adequate support. This is unsurprising given the limited resources and capacities of the MSHP. Some respondents noted that there had been an improvement in the care provided by staff but other felt important gaps remained such as poor reception by staff, patients still being charged for free treatments, and lack of staff motivation and drive to maintain good practices without direct supervision.

Similar to FMCs in Sierra Leone, accountability in health facilities in Ivory Coast was facilitated by the use of CEComs to bridge the gap between the community and the health staff. CEComs held monthly meetings with the facility to discuss challenges with care and concerns from the community. Members note that this has led to an improvement of services and a reduction in complaints about staff, and that they feel respected and listened to by health staff.

An innovative accountability tool was launched as a pilot in select health facilities in Abidjan, providing patients with QR codes to scan with their smartphones to provide feedback. This approach was successful and saw a higher rate of use compared to a traditional suggestion box, and as a result, the MSHP plans to expand its use throughout the country. However, the tool relies on the availably of the internet at health facilities, which is currently provided by PROSSAN, and for

QR Code for Accountability

In order to improve accountability of health facilities, PROSSAN introduced a QR Code in Ivory Coast so patients with smartphones could scan and share feedback more easily than through a traditional suggestion box.

In addition to increasing accessibility, the online accountability system provides an online platform to manage and sort queries more effectively.

The approach is scalable both beyond Abidjan into the whole country, but also into Sierra Leone and Liberia, where internet and smartphone penetration have been increasing.

[6] The ISSAB is derived from UNICEF's Baby Friendly Hospital Initiative.

users to have access to smartphone, thereby limiting the scalability beyond the capital city or into other PROSSAN countries with lower smartphone usage. Adolescents were also engaged directly to provide feedback through a section of the e-santé app and through listening points in their communities.

At the onset of the COVID-19 pandemic, AFD allowed funds from PROSSAN to be redirected to address unexpected needs to respond to the pandemic. This was particular important given the region's previous experience with Ebola and the resulting distrust and fear of health services. At the HQ level, ACF created a COVID-19 task force to provide guidance to country teams on best practices to respond to the pandemic based on shared experiences. As a result, each country of implementation shifting funds towards infection prevention control sensitisation and the provision of protective equipment.

During this period, ACF LIBERIA staff reviewed PROSSAN activities and decided to reallocate funds from this outcome towards COVID-19 response activities. Due to the scope of the budget in Liberia, this resulted in complete halt of activity for MHPSS and to support health facilities to improve the quality of services. Diverted funds were used to support the county health team that was on the verge of collapse due to lack of materials and heighted fear among health professionals, particularly due to the country's previous experience with Ebola. ACF provided IPC, personal protection equipment, and logistic support to Montserrado Country and received a certificate of appreciation for this critical intervention. Health staff noted that the IPC support including monitoring and supervision was critical to ensure services continued to be provided during the pandemic.

Although the shift in funds was critical to respond to the needs in the country, and ultimately COVID-19 activities indirectly strengthened the centres and trust in health providers, it nonetheless created a significant gap for the project. PROSSAN's community-based activities continued, and were designed to encourage greater use of health facilities by women and youth but without the capacity building of centres, many facilities were not able to provide adequate care to meet the increasing demand. Unsurprisingly, endline findings indicate that Liberia did not meet its targets for this outcome, with only 67% of women attending four antenatal care visits and only 41% of births being attended in a health facility, compared to an 80% for both.

COMMUNITY HEALTH PRACTICES AND BEHAVIOURS

The use of community-based groups for outreach to improve health practices was broadly successful in each country, with specific challenges based on context and ownership within the community and government. Focus group discussions showcased the important developments in community member's knowledge, skills and attitudes which resulted in surpassing the project's target to increase women's contraception prevalence rate.

Overall, women and youth were targeted by PROSSAN so activities were developed to address their specific needs, but the lack of gender disaggregated data and the decision to separate groups by gender and age was detrimental in certain occasions were inclusive approach would have been more effective. For example, the use men-only FSGs did not align with best practices identified by community members of conducting outreach with men and women.

Members of community-based support groups in SIERRA LEONE experienced an important improvement in their knowledge, attitude and practices around sexual and reproductive health as a result of PROSSAN activities – at 91% compared to a target of 80% at endline. FGDs indicate that members of FMCs, MSGs and FSGs participated in numerous trainings on key topics such as IYCF, GBV, MHPSS, maternal and child health. The knowledge gained by these individuals was then shared back into the target communities during awareness outreach, educating the broader population on key topics. Awareness raising was often done from household to household, ensuring that members of the community who are reluctant to engage on these topics are still included, while outreach was aimed at hard to reach communities.

Community feedback groups

PROSSAN used community feedback groups – Feedback Management Committees in Sierra Leone and Community Exchange Circles in Ivory Coast – to create a bridge between health facilities and communities. These groups, made up of local leaders and health staff, created an opportunity to share grievances and identify solutions to each centre's challenges. See Annex 13 for more details on the context and goals of the CECom in Ivory Coast.

By fostering conversation between the two groups, trust and respect is rebuilt. Health staff provide better care and treat patients with more respect, which in turn encourages more members to visit the centre. Additionally, community feedback groups use IGAs and VSLAs, providing funds to address critical resource gaps for facilities such as the need for chairs, security guards or trainings.

Feedback groups are a critical link to improve health care and its uptake among the target population. They should be formed of influential community members and providing with the training and seed funding to lead on outreach and income generation independently, however their formal integration into the health facility and wider government approaches is key to continuity. FMCs were officially integrated into the government system during the Ebola and COVID-19 outbreaks, but CEComs have not yet been fully accepted in Ivory Coast.

Members of both MSG and FSG reported high satisfaction and commitment towards the activities of their groups, indicating that the impact on their communities was evident and necessary. Members of these groups were often leaders in their community, including chiefs and religious leaders, who were able to increase the reach of messaging through sermons and bylaws. As a result of the outreach conducted by these groups, and the visible improvements to health facilities noted above, communities' perceptions of health facilities improved. Beneficiaries report this has been demonstrated by an increase in the use and the frequency of visits of PLW, improvements in nutrition of young children, and an observed significant decrease of both maternal mortality and gender-based violence. Community members also shared that their awareness of mental health had changed completely, from believing an individual was cursed to understanding they have a mental illness and referring them to the health facility.

Moreover, members felt their experience in these groups were transformative to their own perceptions. One lead father shared that through the training, there has been "*a consciousness amongst men that we are not bosses for our wives but help mates*". Another noted that as an Imam, he had always felt it was taboo to discuss sex with his daughter, but his membership in the FSG made him realise that his daughter was more at risk of misinformation from the streets and has since spoken to her about family planning, in addition to including it in his sermon. The impact of the participation of men in activities targeted SRH is evident, and should be emphasised and continued. However, in their capacity to do outreach, respondents indicated that these efforts should include both a man and women together given the intervention targets entire households – both PLW

and their husbands. Future community groups should be mixed to maximise the impact of community outreach.

This change was also important for adolescent beneficiaries who participated in AFS and SHCs in Sierra Leone. The adolescents who participated in the FGDs indicated that those who used the AFS were often the most vulnerable – many have been trafficked from the countryside, are not able to attend school and are at risk of prostitution and drug use. As part of PROSSAN, adolescents received individual and group counselling and guidance on topics including family planning, MHPSS, coping mechanisms and the impact of drug use. Youth participants indicated that the newly gained knowledge on these issues and the provision of safe place to share their challenges has transformed their attitudes towards both themselves and their outlooks on life. They report feeling more self-dignity and respect, and have more hope for their own future. As a result, their stress, anger and aggressiveness decrease and adolescents stop their anti-social behaviour. Anecdotally, girls note they no longer turn to the street and to sex for income and have started using family planning. Improvements in their behaviours have allowed them to return to their homes and their families, thereby eliminating the need to resort to prostitution. Endline data indicate that women's contraception prevalence rate, particularly among adolescent girls, almost doubled at the conclusion of the project at 42% compared to the target of 22%. Similarly, boys in FGDs noted they stopped doing drugs and resorting to violence or gangs. Creating a space for adolescents to learn and share has radically shifted their perspectives, and participants are now requesting support to continue looking forwards their future, including going back to school or learning an income-generating skill.

In **LIBERIA**, community-based groups also engaged mothers, youth and adolescents to improve health practices although fell slightly short of their target at 78% compared to 80%. Similar trainings around IYCF, care practices, SRH increased participants knowledge and changed behaviours around health and nutrition such as delivery in health facilities and exclusive breastfeeding. A lead mother noted that one of the MSG's main achievements was the reduction of adolescent pregnancy thanks to their awareness and outreach efforts to educate households on family planning. Health staff echoed this finding, with rates of STIs and teenage pregnancies both decreasing as adolescents were encouraged to visit health facilities to receive family planning commodities.

The lead mother indicates that beneficiaries were successfully identifying and referring cases of both under nutrition and gender-based violence within their communities, including domestic violence and rape, thanks to their training. Cooking demonstrations on how to prepare African baby food and integrate a diverse diet was particularly helpful to improve nutrition of the children. Field staff report a transformation in communities' approach to health and their understanding of nutrition, including linkages and emphasising the importance to child immunisation and backyard farming. However, men were not included in PROSSAN activities in Liberia, and both beneficiaries and staff indicated that this gap weakened the effectiveness of the intervention. The lead mother felt that although the MSG conducted awareness with entire households, the change observed in the community was mostly for women and that men and fathers did not change their behaviours as much, in part due to the lack of men included in the outreach process.

Following a training provided by CHI, community groups in Liberia received seed funding to begin a VSLA. 10% of the group's profits are put into savings for emergency purposes, to provide support to the community for their health needs including transportation costs to reach a health facility. A lead mother noted this process was useful, but that the savings were not adequate enough to meet the group's needs to continue growing their business and to pay for their children's education fees.

Efforts to engage adolescents through the community groups were more challenging. ACF staff felt that adolescents lacked focus and discipline to discuss more challenging topics or use funding for items related to the group – for example using IGA resources to buy foot balls – and required a stronger support structure.

In addition to community groups, adolescents were engaged through SHC to change their SRH behaviour. 6 SHC were initially set up, but one school closed as it was on private property and has not been relocated yet. Despite working closely with the MoE to identify government schools, it is critical to review the wider characteristics of each institution to avoid similar challenges and ensure sustainability of the intervention. Interviews indicate that SHC were effective to transform behaviour, particularly around SRH and hygiene. At the start of the COVID-19 pandemic, groups had been effectively leading routine health awareness campaigns in schools and were able to conduct all of the sensitisation around hand washing and personal hygiene. The MoE noted that schools with SHCs were better equipped and responded more effectively to COVID-19 compared to those without clubs.

Although ACF had initially planned to include a MHPSS component to the SHC, this was not realised due to the reallocation of budget for COVID-19. As a result, monitoring indicates that targets of the number of students reached with SRH and MHPSS counselling was missed at 13%. MHPSS is not currently included in the MoE's guidelines, who viewed this additional aspect as an interesting innovation. The ministry is interested in updating the SHC manual, since was developed in 2016, and wants to create a more holistic and integrated approach that could include mental health priorities.

Activities in IVORY COAST similarly utilised community groups to improve the health practices of women and adolescents in particular and almost met the 80% target at 74% at the end of the project. CECom and adult classes provided trainings on maternal and child health, IYCF, hygiene, and family planning. CECom members conducted outreach and visits to community members homes directly to encourage them to visit health facility and to share key information on best health practices. As a result, respondents indicate that communities' behaviour changed for the better with PLW visiting facilities not only to receive care but also to inquire and learn more about their health needs. Endline data indicate that women's contraception prevalence rate increased to almost double the target at 21% compared to 10%.

Adolescent classes and AFS were led by a psychologist and provided an important forum for young people to gain new knowledge around family planning and MHPSS problems while keeping them off the street. Adolescents indicate that these opportunities allowed them to discuss issues and challenges that they otherwise would not be able to address with their families. However, several young people also indicated that the groups didn't always discuss some of their primary issues around drug abuse and prostitution. Counselling corners, known as 'point d'écoute', were also used to foster more confidential opportunities for adolescents to seek assistance. Although viewed as a replicable success by the PNSSU-SAJ, these points d'écoute were not used regularly and required trained staff who have been reluctant to partake – resulting in the lack of operationalisation or closure of the project's four counselling corners.

E-santé application

In Ivory Coast, an innovative smartphone application was developed for youth called 'e-santé'. This app aims to address the gap in healthcare use by youth, who often feel stigmatised and unable to share their concerns around sexual and reproductive health (see Annex 12 for more details)

It was design in close collaboration between ACF, the PNSSU-SAJ and young people themselves who indicated their interest and needs. The app provided an anonymous 1-1 conversation with a health provider to ask any questions, a forum with other youth to engage on SRH topics, a feedback tool and a referral to in-person care at nearby health facilities. The application is innovative and allows youth to speak on sensitive topics and get the appropriate treatment without fear or shame.

E-santé remains small in scope at it has not been marketed to a wide group and relied on health workers to volunteer their time. There is a need to invest further funding and integrate the responsibilities of these workers into government policies in order to ensure sustainability. The potential of the application beyond its limited launch is enormous.

In addition to these approaches, Ivory Coast launched an innovative smartphone application called 'e-santé' which was targeted at youth in an effort to create an engagement approach that could bridge the gap between young people and their health needs. The application was launched in close collaboration with PNSSU-SAJ and was developed with extensive input from youth who shared feedback on the design of the app and the modules chosen for learning. The application allows youth to sign in anonymously and ask questions and participate in forum discussions on shared challenges around health, mental health and SRH, and get referrals to local health facilities by engaging directly with trained health staff.

Although the reach of the application has been small thus far, staff felt it was an important success and plan to expand marketing to a larger audience. A key challenge to the success of the application is the reliance on unpaid health staff to respond to queries, who have limited time and capacity to give in addition to their regular responsibilities. Some users of the application shared that they waited months for a response to their queries, indicating that the application is not ready to scale up until a sustainable alternative is identified to hire health staff.

ADVOCACY ON NATIONAL HEALTH ISSUES

Advocacy was limited in Sierra Leone to support to community groups, while studies and engagements in Ivory Coast started to take off near the end of PROSSAN 1 following delays in implementation, and will be used for advocacy in the next phase of the project instead and to feed into ACF's global advocacy goals.

In **SIERRA LEONE**, this was accomplished through training of FMC members on advocacy skills and support to create 6-month Action Plans to improve their facilities. For example, the FMC in Kroobay received training on project writing that enabled them to advocate to Orange to pay for the current rehabilitation of their health facility. Observations of health facilities confirmed the development and use of action plans by FMCs. For example, the FMC in Campbell Town identified the need for new WASH facilities and waste management and the inadequate supply of drugs as priority actions. They identified the need to engage the DHMT and government to receive the required resources and the timeline for action. An example of a FMC action plan can be found in Annex 8.

In **IVORY COAST**, advocacy was mostly a success thanks to completed studies, trainings of civil society groups and engagement with the MSHP. 11 civil society organisations for young women were trained on advocacy, and ACF facilitated engagements between said

groups and national actors. Capitalisation was done on key intervention approaches including the ISSAB, CEComs, and the e-santé app and two additional are expected on MHPSS[7]. However, these capitalisation efforts have not yet been used for advocacy. As a result, despite some activities and mentions from the government during conferences, staff did not feel that the advocacy efforts thus far were concrete or had an impact yet. Given delayed timelines, there is an expectation that much of the advocacy activities and efforts will be prioritised during the anticipated PROSSAN 2.

SUMMARY: Overall, the project was effective in meeting some of its objectives, while others were not met, often due to external factors. The large scope of the project, given its budget and staff, created challenges to successfully implement activities as designed. In Sierra Leone, community groups with mothers, father and youths reported significant improvements of their health practices, and PHUs noted improvements in the skills and care provided by staff. In Liberia, strengthening of health facilities and MHPSS activities were not done due to COVID-19, but community groups and school health clubs proved useful to improve knowledge. In Ivory Coast, there were improvements to health facilities and community health practices, but important gaps remain. Innovative approaches such as the e-santé app and the online accountability tool have promise but their current use is limited.

6.4 EFFICIENCY

Table 10: Performance of Efficiency criteria

RATING	JUSTIFICATION
2. Improvement needed	High staff turnover and limited staff capacity for coordination and MEAL resulted in a lack of clarity in roles and responsibilities and had a negative impact on project implementation, relationships with partners, monitoring, and learning. Poor information management and the lack of shared language between all implementing countries exacerbated these challenges.

PROSSAN's efficiency was stunted by high turnover and low staff capacity of both technical and MEAL staff. Combined with weak information management, the project had limited opportunities for learning and project adaptations.

The efficiency of project was severely impacted by challenges around staff, particularly due to the high turnover of ACF staff across all countries of implementation. Ongoing changes in staff and the gaps during recruitment periods impacted communication, organisational learning and information sharing. Partners and ACF staff noted that this gap had a detrimental effect on the support, follow-up and due diligence required to adequately support partners. Challenges with APRs, budgets and implementation were not identified immediately, resulting in delays and increased pressure on staff during reporting periods.

Poor handover practices compounded the negative impact of turnover. Handovers were not conducted effectively and failed to capture historical memory adequately between

[7] The two remaining capitalisation documents are currently being drafted.

new staff. During staff transitions, there should be a review of roles and responsibilities between remaining and incoming staff to provide clarity for all stakeholders.

Weak information management was an additional challenge, which could instead have served to fill organisational gaps during recruitment. Although ACF staff use the organisation's internal system No Hunger Forum, it is not accessible to external stakeholders. As a result, key documents and approaches were not shared regularly with partners but only on an ad-hoc basis. Partners noted this challenge, and requested additional opportunities for experience sharing and capacity building to counter the gap. An external shared space, either through Microsoft SharePoint or Google Drive, should be considered to ensure this access.

PROSSAN's project coordinator was only recruited for the start and the end of the project, perpetuating similar challenges as staff turnover. Additionally, the project coordinator's mission at the start of the project was shortened due to a dismissal. The lack of coordinator during most of implementation prevented cross-country learning and staff felt certain reporting was not done due to this gap. Although ACF HQ was intended to step into coordination during implementation, this was not done adequately due competing priorities.

ACF had weak MEAL capacity in all three countries which impacted both timely reporting and minimised opportunities for learning and adaptations. With no MEAL staff dedicated entirely to the project, each mission's MEAL staff was split between several project and as a result was not able to provide the required oversight to effectively monitor activities. For example, in Sierra Leone, ACF only MEAL Officer was based in Moyamba and rarely had the opportunity to engage with PROSSAN. Planned baselines were not conducted, quantitative reporting spreadsheets were incorrectly tracked, and little evidence was gathered.

Due to limited capacity of MEAL staff, program staff took on some MEAL duties, further blurring the roles and responsibilities of the implementing team. As noted above, a regular review of roles and responsibilities, particularly during transition or low capacity moments, is required to mitigate this lack of clarity.

Due to limited opportunities for learning, there was a severe lack of evidence generation, collection and sharing across the project. Without evidence, activities have not been measured adequately, adaptive management has been limited and opportunities for wider learning and experience sharing have not occurred. This is particularly problematic for Liberia, as PROSSAN was to be a pilot project from which learning could be capitalised for future projects. For multi-year projects, a midterm evaluation should be conducted, in addition to the regular use of KAP surveys and other behavioural metrics to measure changes in behaviours and practices.

The selection of countries for PROSSAN led to additional coordination challenges given the language barriers between Ivory Coast in French and Liberia and Sierra Leone in English. The lack of shared language of staff and for reporting did not allow for maximum sharing of documents and learning, and ultimately doubled the coordination work between countries and with the donor.

SUMMARY: Project efficiency was stunted due to inadequate human resourcing, particularly at ACF. Factors include high staff turnover, the lack of project coordinator, and weak MEAL capacity were a detriment to effective reporting, learning, sharing and adaptive management.

6.5 SUSTAINABILITY

Table 11: Performance of Sustainability criteria

COUNTRY	RATING	JUSTIFICATION
Sierra Leone	4. Meets expectations	Commitment from community members, health staff and DHMT to continue activities, but lack of exit strategy to address resource and finance gaps.
Liberia	3. Overall, meets expectations	Ministries are interested but have little capacity to maintain activities. Limited engagement with wider community or capacity building of local leaders to increase ownership of community-based groups.
Ivory Coast	3. Overall, meets expectations	High commitment from MSPH but important gaps to continue digital innovations without further support. Lack of continuation of community activities in many sites.

The sustainability of PROSSAN activities and impact is somewhat varied across implementing countries. Engagement with the government has been effective but not enough to transfer full ownership of activities. Community members are committed to their groups but lack of resources are a key concern.

Although capacity building and trainings provided to beneficiaries should have a durable impact, noted relocation of health staff and beneficiaries outside of their original locations creates a gap in both service provision and community structures by removing advocates before best practices have been integrated by target populations. Nonetheless, the program's focus on youth and adolescents showcases PROSSAN's focus on the next generation and its potential for longer-term change. Commitment of beneficiaries and ownership by national governments are key to the continuation of activities, but the lack of exit strategies used during PROSSAN 1 will create barriers to transition ACF out of its primary implementing role.

In SIERRA LEONE, beneficiaries indicated high levels of commitment to the project and its impact in local communities. Members of mother and father support groups, AFS, health staff and DHMT officials all noted they would continue activities beyond the end of the project as they can see their impact benefit. However, all shared that despite their best intentions, they would require additional support to meet the high needs of their community particularly around the need for materials, transportation fees, supplies in PHUs etc.

The use of IGAs/VSLAs for community-based groups can address some of these material needs and should be strengthened and expanded to all groups as they serve to both increase income and foster motivation and collaboration between members. Moreover, the group's income can also serve to support health facilities themselves and help fill gaps in government funding. The material need of health staff and government officials should also be considered as without this support they cannot implement on the training received through PROSSAN. Given the challenges to providing funds to cover costs of per diems or transportation regularly, performance-based financing can instead be used to support health staff. Performance-based financing is already being used in each country of implementation through other donors and projects, so PROSSAN can build on pre-existing approaches to make the transition.

Another specific challenge in Sierra Leone is the overreliance of health staff on implementation staff and expectation of constant communication, following a very thorough mentorship model of capacity building. This indicates that health staff do not yet have the confidence or capacity to lead on their own, or that they must be directed to the already stretched DHMT staff for further support.

PROSSAN's SHC activities in LIBERIA were implemented closely with and by the school-based guardian counsellors who work for the MoE. ACF staff trained and then monitored these counsellors to lead SHC activities themselves, and targeted students in grades 9 and 10 to provider longer continuity of participants. These approaches, combined with close partnership with the School Health Division, has led to a strong ownership by the Government of Liberia to continue building on results of the SHCs. However, recent monitoring indicates that not all counsellors are capable of taking full responsibility of their clubs, and that they still require support and supervision from ACF staff. As with community support groups, there have been requests for feed funding and income generating activities – which can be led by students over 18 years of age – to provide resources to sustain the SHC beyond the project.

Additionally, the government's lack of SRH strategy indicates that there is limited ownership by national authorities to continue those specific activities.

Activities in Liberia faced a challenge around ownership from local stakeholders. CHI noted that by design, community-based groups were largely led by PROSSAN staff rather than shifting leadership to the communities themselves. These groups received a lot of training but were not directly engage to build on their own needs and interests, thereby reducing the level of responsibility and ownership of the community members. Although a lead mother felt the group would continue sharing the information gained from training, the need for additional funds and support remains a barrier. As in Sierra Leone, the use of IGA's serves to promote the longevity of activities but further strengthening of groups is required for sustainability. In addition, the lead mother requested that community support groups receive a certificate to acknowledge the training and efforts of the members.

In IVORY COAST, implementation was also done in close collaboration with the MHSP, including the integration of the e-santé app into the government system, thereby enhancing the national authority's buy-in and ownership of activities. One key informant noted that it was easy to sustain the gains from the project as ACF was so well aligned with the national focus. Although the collaboration with the PNSSU-SAJ and integration of the e-santé app has been successful, there are critical challenges around the high time commitment and lack of salaries required for health professionals to respond to youth on the app. Currently, these individuals are providing in the service in addition to their current responsibilities and are often overwhelmed and unable to respond in a timely fashion. Advocacy to the government to integrate e-santé responsibilities into the health worker's approved scope of work would mitigate this challenge.

Efforts to further integrate the app into the government's approaches, including adding participation as facilitators app into the accepted responsibilities of health workers, are required to ensure the activity continues. More outreach and marketing also need to be completed to increase the reach of the app, however this should not occur until the problems around availability of health staff is addressed. Furthermore, moments of weaker collaboration are a risk to sustainability, such as the failure to include DIIS into monitoring and supervision of digitisation.

Several community-based activities in Ivory Coast had already been finalised by the time of the evaluation, and as a result sustainability could be assessed more practically. Adolescents who participated in FGD indicated that although ACF had not supported the

AFS or classes since last year, they remained committed to activities and had been hosting meetings in their own homes. Participants noted using WhatsApp as a new forum for discussion, reaching out to previous members to their input and doing active recruitment to keep the activity ongoing. Nonetheless, health staff also shared that without a dedicated psychologist to provide facilitation to support youth in the AFS

For adult beneficiaries, CECom sustainability was a challenge as the groups do not have official recognition by the government and lack the structures to ensure smooth implementation and follow-up. Field visits indicated that several sites no longer have functioning committees since ACF support ended last year. CECom members felt the support provided for IGAs, including chairs, sounds systems and tarpaulins, did not allow them to meet the financial needs of the activities. This has been exacerbated in two health facilities by the loss of some materials due to a fire on one occasion, corrosion from exposure to the ocean, and the destruction of a AFS due to erosion. The IGA materials provided to CECom's should be reviewed to ensure they are aligned with the environmental context. As in Sierra Leone, IGAs and VSLAs should be reinforced across community-based groups to strengthen cohesion, continuity and enable the improvement of health facilities.

SUMMARY: Sustainability of this project is integrated into the design of the activities, which builds capacity of community and health staff. Beneficiaries express commitment to continue activities beyond the project, but lack of resources and movement of trained health staff and community members are a challenge. Close collaboration with national governments has fostered an integration and shift in responsibility of activities from ACF to each respective government, but there remains a lack of ownership required for long-term sustainability of activities.

10. CONCLUSIONS

RELEVANCE

Overall, PROSSAN's objectives and approaches were relevant to the needs and priorities of the governments and target populations of Ivory Coast, Sierra Leone and Liberia respectively. The design and implementation of PROSSAN was closely aligned with the policies and priorities of each country's national government. Most activities were designed based on government approaches and national strategies and implemented in coordination with district and country level authorities focusing on maternal, adolescent and child health. In Sierra Leone and Ivory Coast, government relevance was evident and successful. In Liberia, the lack of updated government policies on SRH created challenges to ensure activities were aligned.

In general, PROSSAN also addressed the needs of the target populations – both of staff working in health facilities and vulnerable community members. Evidence from implementing staff and beneficiaries indicate that capacity building topics and trainings were useful to fill important gaps in knowledge and skill sets to reduce maternal mortality and improve health practices.

Participatory needs assessments were not consistently conducted in each country of implementation. Activities were designed based on government needs assessments but the lack of systematic engagement with beneficiaries during the design phase resulted in a partial misalignment of priorities. Some respondents note that material support was missing to ensure they were able to implement on the training received, such as the provision of visibility items, medical equipment in health facilities, and transportation subsidies.

COHERENCE

PROSSAN utilised close partnerships with the governments and local organisations to ensure coherence of activities and to build on the existing work being carried out by local actors in Liberia, Sierra Leone and Ivory Coast respectively. Ultimately, the project was designed by ACF with co-implementors, rather than being co-constructed jointly and equally by ACF and its partners.

Coordination meetings with government actors minimised duplication by ensuring that sites selected for the intervention, including health facilities and schools, were not receiving similar assistance from other NGOs and that their needs could be addressed by the intervention. Successful partnerships with relevant government ministries, departments and agencies were particularly noted in Sierra Leone with DHMT and in Ivory Coast with PNSSU-SAJ. Approaches were developed in coordination and joint implementation was effective due to regular and constant communication, use of shared offices and tools, and flexibility from ACF to respond to government needs.

PROSSAN also worked with partners in each country of implementation, with varying degrees of partnership models. Collaboration with SOLTHIS was effective and the INGO contributed significantly to implementation in Sierra Leone, but there was a lack of effort to maximise synergies. Partnerships with local organisations CAWeC and CAPS in Sierra Leone and CHI in Liberia brought in key technical expertise and community buy-in. Partners are satisfied with their experience and the capacity building they received, but request more holistic engagement in the future. In Ivory Coast, two local partners MESSI and AFJCI were only used to implement a small number of low-budget activities on a contractual basis, missing opportunities to build on their strengths.

EFFECTIVENESS

The quality of health services was improved in facilities in Sierra Leone and Ivory Coast through the provision of soft and technical skills and hard materials to health facilities. Skills were developed through trainings on topics of maternal and child health and mental health, and on best care practices such as how to manage and welcome a patient. Mentorship and close supervision further strengthened this learning. Accountability was also reinforced through the use of community feedback groups that created a link between the community and the facility. In Ivory Coast, a series of new digital approaches with a limited scope were successfully used to further enhance care, including digitisation and a QR code to capture feedback and complaints. In Liberia, no planned activities were done towards this outcome as funds were reallocated for COVID-19 response, and were instead used to strength the county health team and ensure health facilities were able to provide services during the pandemic.

Qualitative findings indicate that community-based groups were effective at improving the health knowledge and practices of women and adolescents. Community feedback groups in Ivory Coast and Sierra Leone led on outreach and knowledge sharing within their own communities, further strengthening the link with health facilities. Endline data confirms an increase in women and adolescent girl's contraception prevalence rate in all three countries at the conclusion of the project.

Advocacy efforts were limited during PROSSAN to community-based training and support. However, Ivory Coast was able to develop a series of capitalisation documents at the conclusion of the project, and emphasis on advocacy has been shifted to the next phase.

EFFICIENCY

Lack of human resources at ACF negatively impacted PROSSAN's efficiency. There was a high turnover of technical and implementing staff in each country of implementation, which resulted in loss of organisational knowledge and created gaps in communication and coordination with partners.

PROSSAN also experienced a capacity gap as the project did not have adequate MEAL staff and the project coordinator position was only used at the start and end of the intervention. This forced PROSSAN staff to rely on HQ or non-technical staff, who lacked capacity and direction to ensure adequate monitoring, reporting and coordination.

Lack of information management with all partners and the language difference in the country of implementation reduced opportunities for learning and exchange, which could have increased the intervention's efficiency.

SUSTAINABILITY

PROSSAN worked closely with national authorities, ensuring that activities were aligned with each country's strategies and implemented with government officials. This approach is critical to transfer ownership of activities to the government, however there is little evidence relevant ministries have the capacity to do so.

Additional challenges include the lack of funding required to continue activities – both IGAs for community-based groups and provision of materials for health staff – and the movement of trained staff and community members into new areas before the target population has changed their health practices.

Ultimately, the program relied on the continuation of activities with PROSSAN 2 and therefore rarely implemented exit strategies.

11. RECOMMENDATIONS

The following section outlines a list of recommendations for the next phase of PROSSAN. They include recommendations noted by stakeholders and beneficiaries, and observations from the evaluation team.

MANAGEMENT

- Include the program coordinator position throughout the project, or at least during key reporting periods
- Review and enforce the handover process to capture all information not stored in shared folder and to review roles and responsibilities between remaining/new staff to provide clarity for all stakeholders
- Conduct a joint design exercise and validation workshop with partners of PROSSAN 2 to ensure their inputs and priorities are acknowledged and addressed
- Organise a kick off meeting for PROSSAN 2 with all implementing stakeholders. Review indicators and means of verifications for each, with clear roles and responsibilities

NEEDS

- Review sites selected for PROSSAN 2 with government and partners to ensure priority needs are met and to avoid duplication
- Ensure community needs and priorities are included in PROSSAN 2 activities – review needs identified in evaluation, conduct additional FGDs as needed
- Conduct a study of supply chain to investigate challenges around lack of supplies/drugs and support government to develop action plan
- Narrow focus of intervention in terms of coverage – provide holistic support to less districts to ensure depth of impact

IMPLEMENTATION

Sierra Leone

- Maintain the use of VSLAs and/or IGAs for all community-based groups, and expand to all groups including for youth groups over 18 years old.
- Review activities for PROSSAN 2 to reflect the needs of beneficiaries – there is less need for training and more need for materials/equipment/transportation support
- Shift MSG/FSG into one group with both men and women working together to improve effectiveness of outreach and align with government approach
- Formally engage religious leaders to extend outreach
- Given the success of the AFS, expand the number of spaces or explore options to extend the reach of adolescent activities (ex: use alternative meeting areas outside of health facilities such as markets, schools, water points)
- Identify needs of parents of adolescents and provide training and referrals so they are equipped to support their children
- Provide hard material support to adolescents: support for school fees/textbooks, organising skills trainings

Liberia

- Focus on improving health facilities for targeted communities in PROSSAN 2 to ensure a holistic intervention and avoid sending communities to health facilities that are not equipped to support them
- Review adolescent group activities to ensure they are reflective of the capacities and interest of this age. Either adjust activities to combine with structure such as school/through a new partner, or integrate them as sub group of MSGs until they can move into the separate youth group
- Provide seed funding and (refresher) training to community groups for VSLA/ IGA to promote motivation and group cohesion. Review materials provided for IGA to ensure they are appropriate for the context.
- Review the list of schools targeted for SHC to ensure sustainability, including whether the school is a permanent structure, who owns the land, presence of a guardian counsellor
- Focus government advocacy priorities on improving the infrastructure of health facilities and provide access to services and supplies/commodities
- Include men as beneficiaries of the intervention so they are integrated into MSG and community outreach efforts

- Utilise CHI's rights-based expertise to strengthen the intervention advocacy efforts
- Reintroduce MHPSS awareness and referral activities within community groups and in SHC to address unmet needs due to COVID-19 budget reallocation
- Engage with the MoE to update SHC manual and ensure the inclusion of integrated topics including MHPSS

Ivory Coast

- Review the selection criteria of community representatives for the implementation of the CECom and put in place a process to ensure members are representative of the community
- Reinvigorate mother/father/youth classes and transition skills directly to communities
- Review the materials provided for IGAs to ensure they are appropriate to the context and being utilised effectively
- Advocate with the MHSP to strengthen the institutional recognition of CEComs and the wider federation of CEComs (FECECom)
- Included sensitisation on the cost of services and medication to ensure communities have clarity on what is free and what needs to be paid for when they visit a health centre
- Continue providing supervision and follow up on trainings provided to ensure learning have been integrated by beneficiaries
- Strengthen MHPSS awareness and referral activities at the health and community level to increase access and use of approaches such as the points d'écoute

PARTNERSHIP

- Hold monthly coordination meetings with all partners to discuss opportunities for joint activities, lessons learned, challenges
- Identify additional opportunities for mutual capacity building between all partners based on their mutual technical expertise
- Review ACF's procurement approach to ensure it is in line with district needs and national standards (Sierra Leone)
- Continue ongoing and constant collaboration with district/county level government at all phases of the project
- Review partnership model to ensure it is aligned with ACF's local partnership project and that collaboration strengthens national organisations
- Conduct due diligence and needs assessment of each partner at the start of the project to identify main capacity gaps and develop an action plan to address them.

SUSTAINABILITY

- Ensure exit strategy activities are included in the budget to facilitate a smooth transition at the conclusion of each phase of the project
- Conduct joint exit interviews/workshops/assessment with all partners to avoid duplication of efforts

- Include continued monitoring of PROSSAN 1 sites that aren't being included in PROSSAN 2 to capture impact and sustainability (Liberia and Sierra Leone)
- Conduct advocacy to include facilitation in the e-santé application in the scope of work of national health workers (Ivory Coast)
- Utilise medical students (midwives, nurses, doctors) as facilitator for the e-santé application as they can be highly motivated volunteers and are able to relate more easily to adolescents given their age.
- Explore the use of performance-based financing to motivate and keep health staff accountable rather than supplying per diems
- Ensure each activity includes full inclusion of relevant government ministries in design, implementation and monitoring
    - Specifically on informatisation, include DIIS into supervision and monitoring to build on their expertise and transfer ownership
- Provide certificates to community support groups at the conclusion of the project/training cycle

MEAL

- Review proposal indicators to ensure they are relevant to each activity and can be effectively monitored, outlining all means of verification required
- Conduct Knowledge, Attitude and Practices studies to effectively capture changes in target communities' health behaviour
- Launch formal FCM and share with all partner for joint accountability initiative
- Ensure there is adequate MEAL resources to conduct regular monitoring – set clear expectations and review templates and deadlines for monitoring and reporting with all relevant staff
- Conduct a midterm evaluation of PROSSAN 2 in order to generate evidence for adaptive management
- Conduct quarterly joint workshop with all PROSSAN countries to facilitate experience sharing and learning. Field visits would allow for greater learning, but Teams meetings with concrete agendas and shared documents can also be used
- Conduct baseline assessment for PROSSAN 2 if the PROSSAN 1 endline scope does not provide adequate data
- Develop a shared space for documents, tools, approaches to be shared between partners outside of NHF
- Work in collaboration with governments to enhance their own capacities around MEAL and the use of DHIS2