

# USAID/BURKINA FASO COMMUNITY HEALTH, 2024-2029 ACTIVITY MONITORING, EVALUATION AND LEARNING PLAN

## 1. INTRODUCTION

As part of USAID’s strategic and comprehensive response to the key challenges facing the host country’s health sector, the USAID Burkina Faso Health Office has developed Component Activity 1, entitled Community Health (CH), under the *Improving Health Status and Well-being of the Burkinabe People* Program for FY 2024-FY 2029.

The CH Activity will utilize this Activity Monitoring, Evaluation and Learning Plan (AMELP) as an important tool to plan, track, measure, and report on progress towards achieving the results of the 2024-2029 Health Program in Burkina Faso. In addition, the AMELP will help identify learning opportunities, and effectively adapt programming to respond to challenges and opportunities that arise. The AMELP will be updated regularly; prioritize gender, inclusivity, and include a data analysis plan.

## 2. STRATEGIC APPROACH

### A. Linkages

- The Community Health Activity aligns with the health-responsive objectives of US Embassy of Ouagadougou’s Integrated Country Strategy (ICS) under ICS Goal 3, which seeks “*to Promote Equitable, Economic Opportunity and Social Development*”, and under Goal 3, Objective 3.2, which is to provide “*Assistance and development programs to improve the health of the people of Burkina Faso*”.
- The Community Health Activity is a major piece of USAID/Burkina Faso’s Health Strategy, entitled “*Improving the Health Status and Well-being of the Burkinabe People*” under the USAID/Burkina Faso Health Portfolio for 2024-2029.
- The Community Health Activity also directly relates to the TGOBF’s strategic objectives and priorities contained in the National Health Development Plan (*Plan National de Développement Sanitaire 2021-2030 (PNDS)*) and with the overall vision for the Ministry of Health (MOH)’s national health development plan, which is: “*to improve the health status for all Burkinabe people through an accessible, high-performing and resilient health system by 2027.*”

### B. Theory of Change

To achieve the overarching goal of *sustainably improving the health status and well-being of the Burkinabe people*, the Community Health activity directly supports USAID/Burkina Faso’s broader **theory of change** that:

*If a coordinated set of investments is provided; and  
If access to, and use of, quality service delivery is strengthened; and  
If local communities are engaged in the management of their health; and  
If support is provided for resilient health systems that address priority health interventions and national health security concerns.  
Then the health status and well-being of the Burkinabe people will be sustainably improved.*

The purpose of this new community health activity is *to strengthen the access to, use, and quality of community-based health services*, which is supporting the overall health program goal.

### **C. Results Framework**

CH implementing partners (IPs) must provide a comprehensive, life-of-program Activity Monitoring, Evaluation and Learning Plan (AMELP) in a format approved by USAID/Burkina Faso ([Burkina Faso Health Program AMELP Template FY23](#)). Specific data required are those to measure CH indicators provided in IPs' approved AMELP. Implementation of the CH Component activities and strategies, as summarized in the program description and further developed in IP work plans, are expected to contribute to the achievement of the Health Program Purpose and CH planned results (Rs) and intermediate results (IRs) as listed under the Results Framework (RF) presented below. The RF includes three high-level results and nine intermediate results, in line both with the above-mentioned activity goal and purpose and with USAID/Burkina Faso's broader Health Strategy and results framework developed in 2022. Expected results are as follows:

**Result 1: Improved Access to, and Use of, Community-based Health Interventions**

- *IR 1.1. Increased Use of Quality, Priority Health Interventions and Care at Individual, Household and Community Levels*
- *IR 1.2. Improved Readiness of Public and Private Sector Health Structures to Support Quality, Evidence-informed, Community-based Interventions and Care*
- *IR 1.3. Sustained Equitable Access to, and Use of, Priority, Community-based Interventions during Shocks and Stresses*

**Result 2: Increased Engagement of Local Institutions and Civil Society in Community-based Health Interventions and Disease Control**

- *IR 2.1. Increased Local Capacity to Implement Relevant Health Policies and Practices*
- *IR 2.2. Increased Effectiveness of Civil Society, Local Institutions and Systems to Plan, Coordinate and Manage Quality, Shock-responsive, Priority, Community-based Health Interventions*
- *IR 2.3. Increased Participation by Women, Youth and Marginalized Groups in Community Health*

**Result 3: Adaptive Learning and Use of Evidence for Priority Health Interventions and National Health Security Strengthened**

- **IR 3.1. Improved Availability of Quality, Timely, Community-based Health Information**
- **IR 3.2. Increased Community Capacity and Ownership for Health Information Analysis and Use**
- **IR 3.3. Optimized Use of Community-based Health Surveillance and Reporting Systems**

The 2024-2029 Results Framework may evolve over time, although the technical domains of HIV/AIDS, malaria, maternal and child health, nutrition, voluntary family planning and reproductive health, and health systems strengthening will remain the same. Thus, methodologies for collecting actual data across various implementing mechanisms resulting from the CH Activity will need to be harmonized to meet the needs of USAID’s reporting requirements.

### 3. MONITORING

The USAID Health Office Team, including the CH AOR and IPs together will monitor performance data during each reporting year. They will meet quarterly to discuss and review progress. Depending on the results of these reviews, they may adjust programming and activities. As part of the monitoring process, the USAID Health Office will hold quarterly review meetings with IP staff. Periodically, these review meetings will include staff from the MOH and other key stakeholders. Circumstances permitting, USAID may also conduct joint site visits to the field with IP staff, MOH counterparts, health providers, local community leaders and health actors.

The table below shows monitoring and evaluation tasks and responsibilities across USAID/BURKINA FASO staff members under the 2024-2029 Community Health Activity.

TABLE 1. M&E TASKS AND RESPONSIBILITIES

Action	AOR/COTR	Health Office Director/ Team	M&E Specialists	PRM/SRO
AMELP development	Assist	Responsible	Assist	Consult
Reviewing and updating the AMELP	Assist	Consult	Responsible	Consult
Organizing an orientation session on the AMELP with the Implementing Partner M&E Specialists at the inception of the new activity	Assist	Inform	Responsible	Consult
Collecting performance data from USAID partners (quarterly reports and PITTs)	Responsible	Assist	Assist	Inform
Reviewing and approving	Responsible	Inform	Assist	Inform

performance data (quarterly reports and PITTs)				
Collecting / Reviewing / Approving Annual Performance Report	Responsible	Inform	Assist	Inform
Conducting Data Quality Assessments (DQAs)	Responsible	Inform	Assist	Inform
Submission of indicator data and narratives to PRM for the PPR	Responsible	Responsible	Assist	Consult
Submission of PPR (including editing and verifying information submitted by technical teams, uploading into FactsInfo, coordinating front office and Embassy review)	Assist	Assist	Responsible	Assist
Planning evaluations and special studies including CLA	Assist	Responsible	Assist	Assist
Management of MEL contract	Consult	Consult	Responsible	Consult
Conducting site visits (at least two per year)	Responsible	Consult	Consult / Assist	Inform
Review and approval of AMELPs	Responsible	Inform	Assist	Inform

- R - responsible: Those responsible for the performance of the task. There should be exactly one person with this assignment for each task.
- A - assists: Those who assist and support the completion of the task.
- C - consulted: Those whose opinions and feedback are sought, but not required to respond.
- I - informed: Those who must be kept up to date on progress.
- PITT: Performance Indicator Tracking Table (template)

#### **A. Performance Indicators**

The status of achievement of the Community Health results and outcomes will be measured based on established program indicators, using baselines and midterm and/or end-of-program targets. The IPs will be encouraged to propose additional and/or alternative indicators and targets, including milestones accomplishments as part of their specific AMELPs for the CH Component Activity, including the IPs' approved outcome monitoring approach. The USAID/Burkina Faso Health Team has identified the following preliminary list of illustrative indicators (PIs) to monitor the CH Activity performance over the five-year life-of-program, 2024-2029 (see table 2 below).

**Table 2: LIST OF ILLUSTRATIVE INDICATORS, USAID/BURKINA FASO COMMUNITY HEALTH ACTIVITY, 2024-2029**

<b>Objective/result</b>	<b>Illustrative Indicators</b>	<b>Data sources</b>	<b>Notes</b>
<b>Goal/ICS DO3: Improve Human Health and Social Status</b>	Human development index (HDI) (GDP+Life Expectancy+Education level)	Human Development Index Report (UNDP)	Context
<b>Purpose: To strengthen access to, use, and quality of community-based health services</b>	Newborn Mortality Rate	Demographic and Health Survey (DHS)	Context
	Under-five Mortality Rate	SMART survey	
	Prevalence of under-five stunting		
	Malaria Parasite Prevalence	Demographic and Health Survey (DHS)  Malaria Indicator Survey (MIS)	Context
	Maternal Mortality Rate	Demographic and Health Survey (DHS)	Context
<b>Result 1- Improved Access to, and Use of, Community-based Health Interventions</b>	Percent of under-five children who slept under ITNs	Demographic and Health Survey (DHS)  Malaria Indicator Survey (MIS)	Context
	Number of children who received their first dose of measles-containing vaccine (MCV1) by 12 months of age in USG-assisted programs number of live births.	Demographic and Health Survey  HMIS routine data	Standard
<i>IR 1.1. Increased Use of Quality, Priority Health Interventions and Care at Individual, Household and Community Levels</i>	Percent of malaria cases diagnosed and treated at the community level	<ul style="list-style-type: none"> <li>● HMIS routine data</li> <li>● Implementing Partners</li> </ul>	Custom
	Number of pregnant women reached with nutrition-specific interventions through USG-supported programs	<ul style="list-style-type: none"> <li>● HMIS routine data</li> <li>● Implementing Partners</li> </ul>	Standard

<p>Number of newborns who received postnatal care within two days of childbirth in USG-supported programs</p>	<ul style="list-style-type: none"> <li>● HMIS routine data</li> <li>● Implementing Partners</li> </ul>	<p>Standard</p>
<p>Estimated potential beneficiary population for maternal, newborn and child survival programs</p>		
<p>Number of women giving birth in a health facility receiving USG support</p>		
<p>Number of cases of child diarrhea treated in USG-assisted programs</p>		
<p>Number of cases of childhood pneumonia treated in USG-assisted programs</p>		
<p>Percent of audience who recall hearing or seeing a specific USG-supported Family planning/Reproductive Health (FP/RH) message</p>		
<p>Number of individuals in the target population exposed to USG funded Family Planning (FP) messages through/on radio, television, electronic platforms, community group dialogue, interpersonal communication or in print (by channel/# of channels)</p>		
<p>Number of children under five (0-59 months) reached with nutrition-specific interventions through USG-supported nutrition activities</p>		
<p>Number of children under two (0-23 months) reached with community-level nutrition interventions through USG-supported programs</p>		

	Number of pregnant women reached with nutrition-specific interventions through USG-supported programs		
<i>IR 1.2. Improved Readiness of Public and Private Sector Health Structures to Support Quality, Evidence-informed, Community-based Interventions and Care</i>	Percent of health structures with a functioning system for reference and counter-reference from the community to the health post	<ul style="list-style-type: none"> <li>• Implementing Partners</li> <li>• USAID site visits</li> </ul>	Standard
	Percent of functional community health actors (trained, equipped and supervised).		
	Number of CHWs trained in the use of RDTs and ACTs		
	Number of CHWs performing malaria diagnosis and treatment according to national guidelines		
	Number of live births assisted by skilled workers		
	Number of individuals receiving nutrition-related professional training through USG-supported programs		
Number of USG-assisted community health workers (CHWs) providing family planning (FP) information, referrals, and/or services during the year			
<i>IR 1.3. Sustained Equitable Access to, and Use of, Priority, Community-Based Interventions during Shocks and Stresses</i>	Number of host government or community-derived risk management plans formally proposed, adopted, implemented or institutionalized with USG assistance	Implementing Partners	Standard
	Number of people supported by the USG to adapt to the effects of climate change		

<b>Result 2- Increased Engagement of Local Institutions and Civil Society in Community-based Health Interventions and Disease Control</b>	Percentage of USG-assisted organizations with improved performance	Implementing Partners	Standard
<i>IR 2.1. Increased Local Capacity to Implement Relevant Health Policies and Practices</i>	Percentage of USG-assisted organizations with improved performance	Implementing Partners	Standard
	Percent of local budget allocated to the Health sector	Implementing Partners	Custom
	Percent of functioning Health Development Committees (HDCs)/COGES in targeted areas		
	\$ Value of non-donor resources mobilized at community level for local development priorities	Implementing Partners	Standard
	Number of agreements signed with CBOs or CSOs for implementation of advocacy activities	Implementing Partners others	Custom
<i>IR 2.2. Increased Effectiveness of Civil Society, Local Institutions and Systems to Plan, Coordinate and Manage Quality, Shock-responsive, Priority, Community-based Health Interventions</i>	Number of host government or community-derived risk management plans formally proposed, adopted, implemented or institutionalized with USG assistance  Number of institutions with improved capacity to assess or address climate change risks supported by USG assistance	Implementing Partners	Standard
<i>IR 2.3. Increased Participation by Women, Youth and Marginalized Groups in Community Health</i>	Number of USG-supported activities designed to promote or strengthen the civic participation of women, youth and marginalized groups	Implementing Partners	Standard

<b>Result 3: Adaptive Learning and Use of Evidence for Priority Health Interventions and National Health Security Strengthened</b>	Percent of recommendations (derived from investigations) implemented	Implementing Partners	Custom
<i>IR 3.1. Improved Availability of Quality, Timely, Community-Based Health Information</i>	Percent of CHWs submitting timely monthly reports	<ul style="list-style-type: none"> <li>● HMIS routine data</li> <li>● Implementing Partners</li> </ul>	Custom
	Percent of CHWs submitting complete monthly reports		
<i>IR 3.2. Increased Community Capacity and Ownership for Health Information Analysis and Use</i>	Number/percent of community platforms (including women and youth groups) supported for oversight of health services	Implementing Partners	Standard
	Number of people using climate information or implementing risk-reducing actions to improve resilience to climate change as supported by USG assistance		
<i>IR 3.3. Optimized Use of Community-based Health Surveillance and Reporting Systems</i>	Percent of CHWs trained in the community based event surveillance system	<ul style="list-style-type: none"> <li>● HMIS routine data</li> <li>● Implementing Partners</li> </ul>	Custom
	Percent of community event-based surveillance reported and investigated		

### **B. Data collection**

Implementing Partners (IPs) will collect on a regular (quarterly, semi-annual, and annual) basis and analyze contextual, impact, and performance data to monitor the progress of the CH Activity and, if necessary, update the AMEL Plan. Baseline data for the proposed indicators addressing Maternal and Child Health (MCH), Family Planning (FP) and malaria will be collected by the Demographic and Health Survey (DHS). Additional data on malaria will be collected through the Malaria Indicator Survey (MIS) scheduled in 2024. Performance and monitoring data on HIV will continue to be collected as part of the PEPFAR program. The CH Implementing Partners will emphasize the DHIS2 routine data collection system for their information needs, reinforcing this important TGOBF system to model the data used to inform decision-making. Other indicators in the AMEL Plan will be collected through routine data collection, including monitoring data collected by the IP and the DHIS2. The USAID AOR and Health Office will

ensure regular data quality audits are conducted to ensure the quality and accuracy of the data. Endline data will be collected through the DHS, DHIS2, depending on the timing of these studies, and by the IPs, as deemed necessary.

### **C. Context Monitoring:**

Context monitoring refers to monitoring local conditions that may directly affect implementation and performance, such as non-USAID projects operating within the same sector as USAID projects, or external factors that may indirectly affect implementation and performance, such as macro-economic, social, or political conditions. Context monitoring should be used to monitor assumptions and risks identified in the technical approach (and/or logical framework) of the Community Health Activity. In order to have a sound monitoring system, applicants will propose indicators, determine ways to set baselines, set realistic targets for performance indicators, and establish effective procedures for internal data quality control.

The USAID Health Office Team will monitor the following indicators with regard to key assumptions necessary for the achievement of the project purpose:

- The percent of local governments' budget allocated to health sector activities. The budget should be steadily rising to meet Burkina Faso's commitments under the Abuja Declaration. Any reductions in local governments' health expenditures will be discussed among the CH team and elevated to the local governments, TGOBF MOH, SRO and Mission Director, as needed, for further action and consideration.
- Immunization rates to ensure that the change in status for Gavi funding does not have any adverse effects on vaccination rates.
- Disease outbreaks in the nine geographic focus regions and across Burkina Faso. While USAID and the U.S. Government Interagency Team have robust programming in Global Health Security, any outbreaks, such as dengue or meningitis, could have serious ramifications.

### **D. Managing for results**

The USAID Health Office and CH AOR are responsible for ensuring full participation and collaboration of their implementing partners in monitoring the overall performance management system of the Community Health Activity as part of the overall USAID Health Portfolio for 2024-2029.

As the CH Activity develops and evolves, the AOR, IPs and Health Office Team will utilize an adaptive management approach to the project, actively monitoring implementation, assessing progress, and identifying necessary adjustments and refinements. The designated AOR and the Health Office Team will ensure that the AMELP is consistent with the data requirements of the overall Health Portfolio. The AOR and the team will play a key role in learning and adapting as frontline staff engaged in activity supervision, data analysis, and other relevant performance information shared by IPs, the MOH and other key stakeholders. This will enable the staff to recommend important course corrections, such as adjustments to ongoing work plans or modifications to implementing mechanisms.

### **E. Assessing Data Quality**

Data quality assessments (DQAs) will be an important tool that will be used to help the AOR and Health Office Team to assess and understand how confident they should be in the data used to manage a program and report on its success. It will also ensure that the team is aware of the strengths and weaknesses of the data, as determined by applying the following five data quality standards: Validity, Reliability, Precision, Integrity and Timeliness. These assessments will also raise USAID awareness of the extent to which the data integrity can be trusted to influence management decisions, as well as the apparent accuracy and consistency of the data.

Data quality assessments are carried out by AORs, Activity Managers and GATRs (Government Agreement Technical Representatives) themselves with the support of the M&E Specialist in PRM (or SRO) and not delegated to an outside partner. The Health Team is responsible for ensuring that all members/activity managers integrate data quality assessment into ongoing activities (e.g., combine a random check of partner data with a regularly scheduled site visit). This enhances management of activities and minimizes the costs associated with data quality assessment. Team members will use the USAID/Burkina Faso Data Quality Checklists to conduct the data quality assessments). DQA findings, recommendations and follow-up action will be documented in project files and within Program Office/SRO Files.

## **4. EVALUATION**

Performance indicators only “indicate” progress and cannot be used to determine “why” a certain result occurs. Evaluations and special studies are ways in which sub-teams will complement routine performance monitoring efforts with more rigorous, in-depth analysis on topics of special interest.

The Health Office anticipates conducting a mid-term, cross-cutting evaluation of the 2024-2029 CH Activity that includes multiple implementing mechanisms. The Health Office Team will work closely with the Program/Sahel Regional Office in the design of the evaluation, including planning for data collection, the timing of the evaluation and use of the mission-wide mechanism or another third party (external) organization to conduct the evaluation. Specific activities may also conduct final evaluations. The choice of evaluation methods, if any, will be discussed during the activity design phase.

## **5. COLLABORATION, LEARNING AND ADAPTATION (CLA)**

### **A. Overview**

The Community Health Activity is a critical component of the USAID Health portfolio in Burkina Faso, which will contribute vital information and learning to enhance approaches to improving the performance of the health sector. The monitoring, evaluation, and learning (MEL) system should use USAID’s Collaboration, Learning, and Adapting (CLA) principles (consistent with ADS 201.3.5.19) to effectively integrate real time monitoring and learning back into activity implementation and ensure knowledge is shared with the broader Health community. As a matter of principle, the CH Activity will rely on and reinforce, wherever possible, existing data collection systems and avoid the creation of parallel reporting systems. USAID Health activities will, within

their respective scopes of work, seek to strengthen the ability of people at all levels to access and utilize data for informed decision-making.

The Health Office will facilitate collaboration, learning and adaptation across the health portfolio through several approaches. First, the USAID Health Team will continue to hold annual joint review meetings, chaired jointly by the Health Office Director and the Secretary General of the MOH. Second, the USAID Health Office will hold quarterly meetings with the IP Chiefs of Party. Third, if officially authorized and circumstances permitting, the Health Team will conduct six-monthly joint site visits to the field to discuss successes, challenges and lessons learned, with IP staff, MOH counterparts, local community health providers, leaders and health actors. Fourth, the AOR and Health Team will utilize a MEL activity to assist with the compilation, analysis and sharing of data collected by the TGOBF (DHIS2) and IPs to closely monitor health system performance.

#### **B. CLA Issues/Questions**

The CH Activity will develop a preliminary learning agenda that identifies a limited number of questions/issues related to the activity's theory of change. These questions will inform USAID's health learning agenda in Burkina Faso.

Close and systematic collaboration with other USAID IPs, the government of Burkina Faso, decision-makers, and institutional bodies among the target communities, and other key stakeholders will be critical to maximize the use of learning and ensure that monitoring and evaluation systems are as cost-effective as possible and do not create a parallel system. The CH Activity will be expected to collaborate closely with the USAID MRCS mechanism and actively participate in meetings, workshops, and learning-related activities, identify a CLA focal point among its staff, and support attendance by local stakeholders at key learning events with health activity partners.