USAID Benin Private Sector Health Partnership Activity Monitoring, Evaluation, & Learning Plan

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Component Name: USAID Benin Private Sector Health Partnership Activity

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Implemented by: Abt Associates

Partners: MCDI, EnCompass

Acronyms & Abbreviations

ACT	Artemisinin Combination Therapy
AMELP	Activity Monitoring, Evaluation and Learning Plan
AMTSL	Active Management of Third Stage of Labor
ANCRE	Advancing Newborn, Child and Reproductive Health
ANMPE	Association of Small and Medium Enterprises
ARM3	Accelerating the Reduction of Malaria, Morbidity, and Mortality
CHWs	Community Health Workers
CoP	Chief of Party
COR	Contracting Officer's Representatives
DDP	Direction de la Planification et de la Prospective
DHIS2	District Health Information System 2
DQA	Data Quality Assurance
EMMP	Environmental Mitigation and Monitoring Plan
FBO	Faith Based Organization
GoB	Government of Benin
HF	Health Facility
IR	Intermediary Result
LOP	Life of Project
PIRS	Performance Indicator Reference Sheet
PMP	Performance Management Plan
PNS	*Plan National de Santé*
PSSP	Private Sector Health Platform of Benin (*Plateforme du Secteur Sanitaire Privé*)
PS	Private Sector
PPR	Performance Plan and Report
PSA	Private Sector Assessment
PSHPA	Private Sector Health Partnership Activity
RACI	Responsible Accountable Consulted Informed
RDQA	Routine Data Quality Assessment
RF	Results Framework
RMNCH	Reproductive Maternal Neonatal and Child Health
SHOPS	Strengthening Health Outcomes in the Private Sector
SNIGS	*Système National d'Information et de Gestion Sanitaire*
TA	Technical Approach
TBD	To Be Determined

ToC	Theory of Change
UHC	Universal Health Coverage
USAID	United States Agency for International Development
USG	United States Government

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1. Introduction

This Private Sector Health Partnership Activity (PSHPA) Monitoring, Evaluation and Learning Plan (AMELP) serves to:

- Guide the course, speed, and the method of program implementation, by comparing the achieved results with desired results from activities; and
- Support the use of program monitoring, evaluation and learning in work plan development and project implementation.

The AMELP accomplishes these objectives by:

- Documenting the program's Theory of Change and Results Framework;
- Establishing a learning agenda;
- Providing metrics for measuring the progress of PSHPA towards achieving objectives;
- Establishing guidelines for the collection, management, quality assurance, storage, analysis and use of data; and
- Defining responsibilities from the point of collection through use.

1.1 Activity Technical Approach

PSHPA is a five-year USAID project (2018-2023) that seeks to empower the Government of Benin (GoB) to be a market-driven steward of the health system with increased engagement and oversight of the private sector. The project builds on USAID investment in 2013 and 2014 in two studies: the Benin Private Sector Assessment (PSA) and Benin Private Sector Census.[1] Using the PSA and Census recommendations as a blueprint, USAID/Benin has invested in the private sector through the following projects: Strengthening Health Outcomes through the Private Sector (SHOPS), Health Finance and Governance (HFG), Accelerating the Reduction of Malaria, Morbidity, and Mortality (ARM3) in Benin and Advancing Newborn, Child and Reproductive Health (ANCRE). These projects laid the foundation for increased private sector engagement in improving Reproductive, Maternal, Newborn and Child Health (RMNCH) outcomes, which is the focus of PSHPA.

1.2 Activity Theory of Change

Several key assumptions underpin the PSHPA theory of change. Firstly, it assumes that PSHPA can contribute to the GoB's ongoing reforms to the private health sector and that no political issues will delay these reforms. The theory of change also assumes that the GoB and MoH will see PSHPA collaboration as an opportunity to facilitate the reforms and that the GoB and MoH have the bandwidth to work with PSHPA despite the urgent nature of the reforms. In addition, it assumes that natural disasters (epidemics, floods), political events and other uncontrollable events in Benin would not affect the timeline for activity nor project implementation.

[1] Carmona, Andrew, Sean Callahan, and Kathryn Banke. 2014. *Benin Private Health Sector Census.* Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

The PSHPA Theory of Change (ToC) (Figure 1) posits that if we:

- Empower the GoB to be a market-driven steward of the health system;
- Streamline regulations and standards;
- Scale up promising private sector (PS) approaches; and
- Strengthen the capacity of the Plateforme du Secteur Sanitaire Privé (PSSP) then we will increase the use of high impact RMNCH products and services delivered by the private sector. This will in turn contribute to the reduction of preventable deaths, including deaths among traditionally underserved, vulnerable populations[2], and improve health outcomes for the Beninese population.

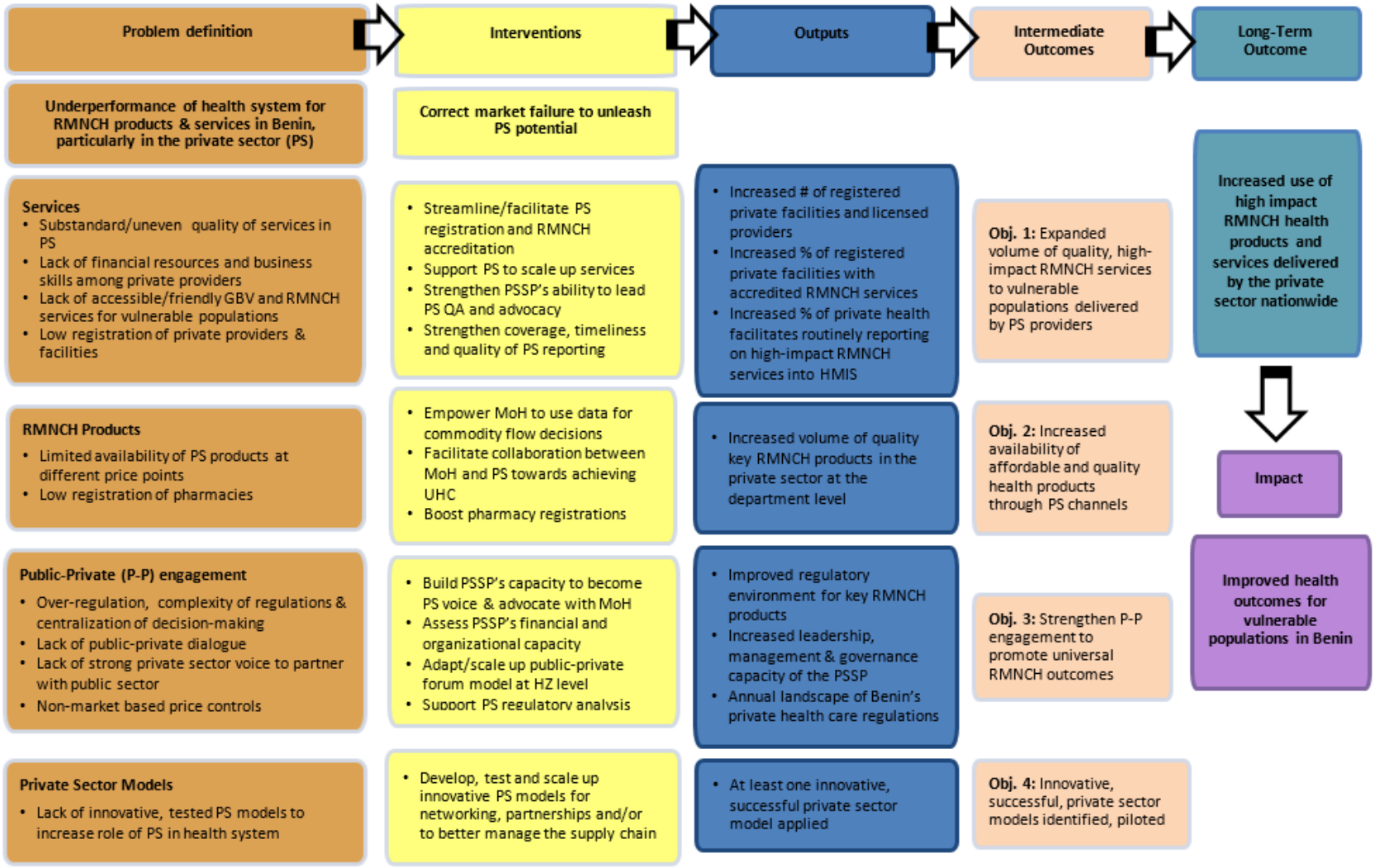
Therefore, our approach involves:

- Streamlining Private Sector (PS) registration and RMNCH accreditation
- Supporting PS to scale up services
- Strengthening PSSP's ability to lead quality assurance and advocacy
- Strengthening coverage, timeliness and quality of PS reporting
- Strengthening PSSP ability to provide gender- and youth-inclusive services
- Empowering Ministry of Health (MoH) to use data to make decisions about commodity flows
- Facilitating collaboration between MoH and PS towards achieving Universal Health Coverage (UHC)
- Building PSSP's capacity to become a PS facilitator and advocate with MoH
- Adapting and scaling up a public-private forum model at the health zone level
- Supporting a regulatory landscape analysis
- Developing, testing and scaling up innovative PS models on networking, partnerships and better management of the supply chain.

A focus on learning is foundational to this AMELP, which we aim to align with USAID/Benin's learning objectives. As in the USAID evaluation policy, our approach aims to make use of monitoring, evaluation and learning findings to inform project design, make programmatic adjustments as possible, and systematically generate knowledge. Our approach to learning recognizes that it is critical to ask the right questions at the right time. This AMELP will therefore serve as a dynamic management tool to enable continuous learning and adapting to maximize performance. It will facilitate adjustments when there are changes in context, project priorities or expected results, or when refinements are made to interventions based on learnings. We will systematically analyze and address the root causes of private sector underperformance; identify, pilot, fine tune and implement / replicate successful private sector models; and introduce, plan and implement innovations to increase the availability and use of high quality RMNCH services through improved private sector performance.

[2] Vulnerable populations are defined by the USAID Benin Strategic Framework 2017-2021 as student girls, girls in school, women and Benin's most marginalized groups, including the extremely poor and at-risk populations.

Figure 1: PSHPA's Theory of Change



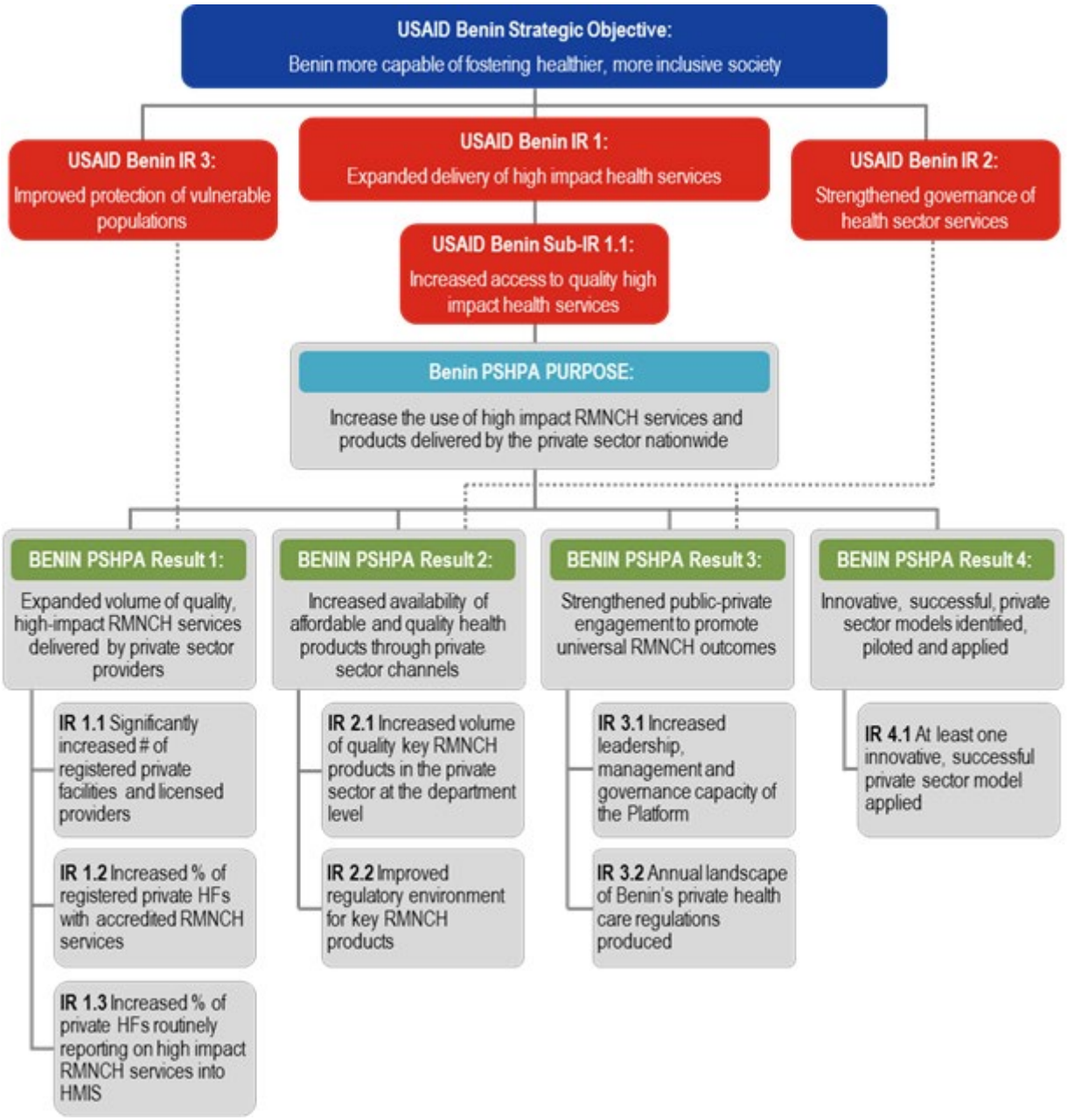
1.3 Results Framework

The PSPHA Results Framework (RF) (Figure 2) integrates the ToC elements into an actionable framework that guides all project activities. The overall purpose of PSHPA is to increase the use of high-impact RMNCH services and products delivered by the private sector nationwide. There are four results:

- Result 1: Expanded volume of quality, high impact RMNCH services delivered by private sector providers
- Result 2: Increased availability of affordable and quality health products through private sector channels
- Result 3: Strengthened public-private engagement to promote universal RMNCH outcomes
- Result 4: Innovative, successful, private sector models are identified, piloted, and applied

PSHPA's results framework maps to the results framework for USAID/Benin's five-year (2015–2020) health strategy, which aims to reduce preventable deaths among vulnerable populations through increased use of high impact health services and healthy behaviors at the community level. The PSHPA RF shows how the four project results (and IRs) link to USAID/Benin's overall intermediate results, which include: 1) expanded delivery of high impact health services; 2) strengthened governance of health sector services; and 3) improved protection of vulnerable populations.

Figure 2: PSHPA Results Framework



2. Monitoring Plan

2.1 Performance Monitoring

Our indicator summary table (Annex I) includes performance monitoring indicators with associated baselines, targets, source and data collection method, and reporting frequency. The indicator summary table follows closely the PSHPA contract fee table. Indicator targets and results will be dependent on data availability in DHIS2 for a subset of facility and service delivery indicators.

Data will be disaggregated by geographical area, cadre, sex, age, rural/urban location and/or product, as applicable. Indicator targets are estimated for each year based on expected project activities. Each year, PSHPA indicator targets will be reviewed, updated and resubmitted as part of the annual work planning process.

2.2 Context Monitoring

The M&E Manager will ensure that all PSHPA assessments, surveys, research studies, and other data collection efforts take into consideration the environmental, climatological, economic, social or political factors, programmatic assumptions, and operational context. The Environmental Mitigation and Monitoring Plan (EMMP) complements this AMELP for the project and was submitted to USAID separately.

PSHPA will work closely with USAID to monitor the progress of ongoing GoB health reforms. PSHPA plans to establish a Reforms Task Force with representation from USAID, MOH and PSHPA to discuss quarterly how the ongoing reforms affect project activities, priorities and performance goals.

Table 1. PSHPA indicators potentially impacted by Government of Benin Reforms

1.1.1	Number of private health facilities registered
1.2.1	Percent of registered non-accredited private health facilities receiving quarterly accreditation visits
1.2.2	Percent of registered private facilities accredited (after completion of 2 years of visits)
1.3.1	Percent of registered private health facilities supervised at least once by the MoH in past 6 months
1.3.2	Percent of registered private health facilities reporting to health management information system (HMIS) on quarterly basis
2.2.1	Number of private pharmacies or depots registered at arrondissement level

Additional GoB ongoing reforms involve integration of private health sector statistics into the District Health Information System 2 (DHIS2). The 2019 HMIS Annual Plan, which PSHPA participated in, envisions tagging private health facilities with a specific code to allow data runs and potentially developing private-sector specific indicators in the DHIS2. PSHPA will provide technical assistance for this process and will amend the AMELP to include service statistics (outcome) indicators when additional private sector-specific data is available in the DHIS2.

3. Strategic Evaluation and Learning Agenda

PSHPA will collect and use information throughout the implementation process to evaluate its activities, learn from implementation, and further refine and adapt its approaches.

Relevant PSHPA staff and stakeholders will institute learning meetings and data reviews on a quarterly basis to discuss achievements and challenges and support program management decision-making and mid-course corrections. By regularly scrutinizing and reflecting on our processes and our indicator data, PSHPA staff can ensure continuous program learning and adaptation.

The PSHPA strategic learning and evaluation agenda centers around priority areas articulated in the ToC and in the proposed FY19 workplan. PSHPA will reflect on a series of questions related to common characteristics of program quality as the starting point for questions addressed through routine monitoring and analysis of our performance indicators. These include questions related to effectiveness (Did we meet our targets? Were our targets appropriate? Given progress to date, are we on track?), Relevance (Has the context changed?), Efficiency (Are there more economical or faster ways of achieving our results?), and Impact (Are we achieving intended results? Are we aware of any unanticipated positive or negative effects?).

The PSHPA strategic evaluation and learning agenda table below (Table 2) details Year 1 learning and evaluation questions and activities, the resources needed to answer these questions, and how this information could be used to inform programming.

Table 2. PSHPA Strategic Evaluation and Learning Agenda

Learning and Evaluation Questions	Timing / Key Decision Points	Learning Activities	Resources
1. What are key barriers and drivers for streamlining private sector registration, licensing and RMNCH accreditation processes?	Semi-annually/ PSHPA will use results to adapt approach	Internal learning discussions	Notes from deregulation, registration, task force meetings (for internal use)
2. Have PSHPA-supported private providers improved their technical and managerial knowledge? What adjustments need to be made to increase the effectiveness of trainings?	Post training/ PSHPA will use results to adapt training topics and strategy	Internal data reviews and learning discussions post training	Pre/post training questionnaires to evaluate knowledge gain (for internal use)
3. Are PSHPA-supported private providers able to provide high quality RMNCH services? What adjustments need to be made to increase the effectiveness of on-the-job trainings?	Quarterly/ PSHPA will use results to adapt on the job training topics and strategy	Internal data reviews and learning discussions post supervision visits	Supervision checklists to evaluate capacity to provide high quality services
4. After DHIS2 project activities, do more private facilities report/submit their data to the health districts and DHIS2? If not, what are remaining challenges and barriers?	Quarterly/ PSHPA will use results to adapt DHIS2 approach	Spot checks of private health facilities and review DHIS2 records	DHIS2 records, follow up visits to health facilities to evaluate capacity and willingness to report to DHIS2
5. What are key barriers and drivers for increasing availability of RMNCH products in the private sector?	Post Interviews with stakeholders as part of mentoring activities/ PSHPA will use results to adapt approach to	Semi-annual PSSP meetings to include discussion of increasing availability of RMNCH products	Notes from meetings with stakeholders (for internal use), market data exercises

	increasing product availability	in the private sector	
6. How is the MoH using pharmaceutical statistics to improve the supply of RMNCH products in Benin?	Post IQVIA data provision	Roundtables and informal workshops with key MoH stakeholders	IQVIA pharmaceutical data
7. How are health sector recipients of loans improving access to products and quality services?	Annually/PSHPA will use results to inform future access to finance activities	Internal data reviews and learning discussions on use of financial resources	Interviews with health sector recipients (for internal use)
8. To what extent has the capacity of the PSSP leadership and collaboration with the MoH improved? To what extent has the management/stewardship capacity of the MoH improved?	Annually/PSHPA will use results to inform additional capacity building activities with the PSSP and the MoH	Exchange meetings with the PSSP and the MoH and internal learning discussions	Notes from meetings with the PSSP and the MoH to document capacity improvements (for internal use)
9. To what extent is the project addressing gender gaps identified through the Benin 2015 gender analysis and PSHPA Year 1 rapid gender analysis?	Annually/PSHPA will use the gender analysis findings to review progress and inform project activities as part of annual workplanning	PSHPA internal gender and youth technical updates and discussion of progress, challenges, and strategies to address gaps across activities	Benin 2015 gender analysis report, PSHPA Year 1 gender analysis report, Year 2-5 annual workplans

4. Data Management

PSHPA will use a mix of existing and project-generated data. We are committed to supporting sustainable data collection systems, and will use and support existing information systems as a data source to the extent possible. For instance, we will facilitate and incentivize improved reporting of private sector services into the MoH DHIS2 HMIS platform, ensuring access to quality data, and building the capacity of both the MoH and PS to use collected data for informed decision-making. The PSHPA M&E Manager will also work closely with MoH HMIS team to obtain specific private sector performance indicators from the DHIS2 platform.

PSHPA will support strengthening of the data management system by: 1) facilitating Private Health Facility (PHF) training on DHIS 2 led by the Direction de la Planification et de la Prospective (DDP)/MoH; 2) supervising the quality control of health zone data for the private sector; and 3)

organizing quarterly meeting of health area statisticians under the leadership of the MoH and the PSSP on synthesis of data quality and evidence-based decision making.

The Gender and Youth Specialist will work closely with the M&E Manager to ensure that, to the extent possible, gender and other equity determinants (like age and sex of provider) are integrated into the design and analysis plans for all assessments, studies, and other data collection efforts. We will also conduct a rapid gender analysis in Year 1 to fill any gaps in the Benin 2015 gender analysis and develop a project gender strategy that will identify gender- and youth-related priorities for each objective, and ensure that gender considerations are an integral and ongoing part of project monitoring, evaluation, and learning. As described in learning question 9 of Table 2 above, findings will be considered during annual workplan discussions and activity planning. Processes PSHPA will use to improve private sector data flows include:

- Training on DHIS2 data entry and submitting to health zones for private facilities in collaboration with MoH and PSSP;
- District level quarterly meetings on data management with public and private stakeholders;
- Periodic PSHPA data management inspections at the facility level as part of accreditation visits.

4.1 Data Collection

PSHPA staff and partners will routinely collect program data and information during implementation. The main data sources for the indicators include pharmaceutical data reports, MoH registration and DHIS2 reports, training logs, rapid assessments, and meeting minutes.

In collaboration with the HMIS/MoH team, the PSHPA team will train private health facility staff to use the HMIS data collection tools and data entry in DHIS2. In addition, the PSHPA M&E Manager, in collaboration with the HMIS team at the Ministry of Health, will oversee the regular collection of HMIS data from private health facilities. The PSHPA Performance Plan and Report (PPR) and Performance Monitoring Plan (PMP) indicators that are not in the HMIS will be integrated during the general tool review workshop which includes the integration of new tools under the authority of the MoH. The M&E Manager will design and provide a business report template to the relevant technical staff to encourage consistency in the reporting template. These models will compile and organize the data so that it can be easily evaluated. Where appropriate, data will be disaggregated by geographical area, setting, gender, age and rural/urban area, and will be reported on a quarterly basis.

PSHPA will adopt appropriate data presentation methods such as tables and graphs. In addition, PSHPA will analyze trends and patterns in the data to determine progress due to project interventions and provide useful information for program decision-making. The summary of data collection methods is included in the Performance Indicator Reference Sheet (PIRS) of each indicator (Annex II), as well as the frequency with which data will be collected, including any limitations or potential difficulties.

4.2 Data Quality Assurance

PSHPA will conduct internal data quality reviews through a systematic, Routine Data Quality Assessment (RDQA) based on USAID's RDQA process and checklist, which provides a common approach for improving overall data quality. PSHPA's M&E Manager will assess reported data and regularly monitor and improve the underlying management and systems. PSHPA's use of this process will streamline USAID's own data audit process by integrating similar measures of data quality including validity, integrity, reliability, precision, and timeliness. The project will integrate the RDQA procedures into its systems to verify the quality of reported data and continuously assess the underlying data management and reporting systems for standard project-level output and outcome indicators.

Providing consistent and useful feedback to activity managers and partners and making use of the collected data for management and decision-making encourages the project team to maintain data quality. It also ensures that reporting is complete and accurate. A primary level data quality check will be done at the project level where the partners and project team obtain reliable, accurate, precise data and associated means of verification in alignment with the PIRS. After data is collected, it will be entered into an Excel-based database and reviewed by the M&E Manager on a quarterly basis. The Home Office M&E and technical teams also provide support to verify data on a quarterly basis.

As part of the internal RDQA process, the M&E Manager will:

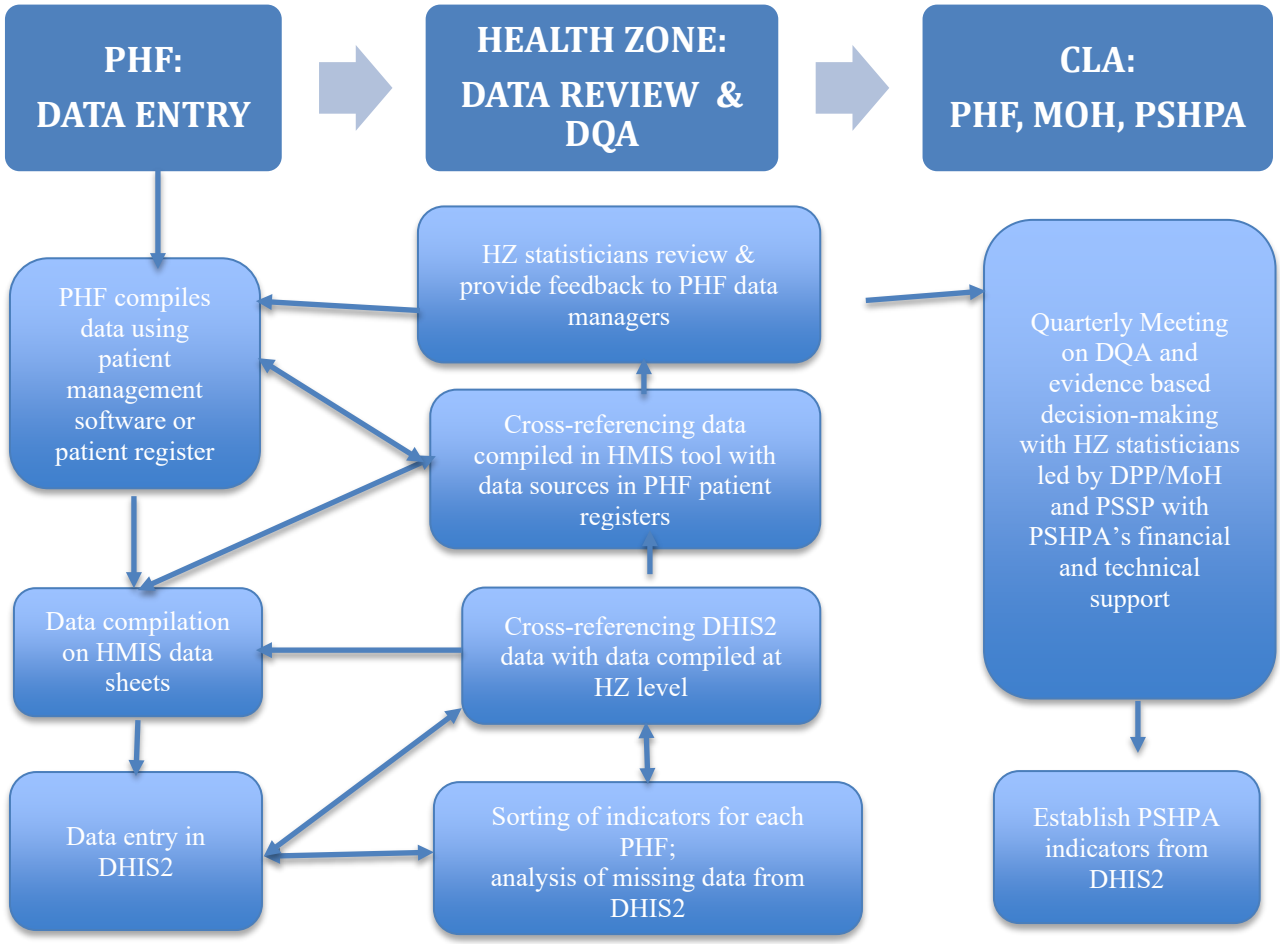
- Ensure the timeliness and accuracy of data through quarterly data validation meetings with partners and organizations supported by the project.
- Review data for missing data (blanks), possible errors, and cross-check against means of verification or supporting documents. This includes ensuring the means of verification are available, and following up on any missing means of verification with the project team. These findings will be shared with the country team for review and discussion to identify next steps.
- Make changes to entered data and means of verification as needed.

The M&E Manager will strategically assess the reported data and provide quarterly recommendations to improve the underlying data management and reporting systems. Specifically, the M&E Manager will review the validity and appropriateness of all data collected, including by partners. The M&E Manager will review the data content and format as well as the appropriateness for the indicators they support. At the end of each month, the COP will work with the M&E Manager to validate the appropriateness of the data. Any questionable data will be subject to rapid field assessment for 1) monitoring the data entry into DHIS2 and 2) monitoring data sources on a sample basis before quarterly submission to USAID. The PSHPA M&E Manager and technical advisors will conduct unannounced site visits and/or on-site training each time they are in the field. This process serves to streamline the efforts of USAID's own data audit process by integrating measures of data quality including accuracy, reliability, precision, and completeness.

Additionally, PSHPA will ensure that reported data is replicable, meaning that data sources will be available with corresponding documentation sufficient to recreate results to justify conclusions. PSHPA will also use a Data Quality Assessment Checklist. Figure 3 provides the data management

and DQA flow at the level of the private health facility, health zone, and among stakeholders involved in the Collaborating, Learning and Adapting (CLA) process.

Figure 3: Data management and DQA flow for indicators calculated from DHIS2



4.3 Data Storage and Security

Project data will be entered and stored in Excel spreadsheets on the PSHPA local server in Cotonou, with a backup on the Abt Associates headquarters' server in Rockville, Maryland. All PSHPA staff computers are protected with an individual password and are therefore inaccessible by non-PSHPA staff. Hard copies of data (original documents) are additionally stored in a locked cabinet. IT security will focus on ensuring the integrity, confidentiality, availability, and authentication of electronic project data. Reports will be preserved as electronic documents and will be archived in a folder system.

4.4 Data Analysis and Use and Dissemination Plan

All data collected will be analyzed to report progress against indicators. The PSHPA M&E Manager will work with technical team members on data analysis linked to the team's respective

area of intervention. PSHPA will aggregate and regularly report results to USAID on a quarterly and annual basis. Training data will be reported on TraiNet.

Supported by the Home Office M&E team, the M&E Manager will hold routine learning meetings to ensure that the data generated for monitoring and reporting is used by staff to identify planned and unplanned achievements and challenges. These meetings will support program management decision-making and mid-course corrections.

In line with our management approach, we will operationalize this flexibility by using the following key processes for analyzing and using data for learning and adapting as described in Table 3:

Table 3. Key Processes for Analyzing and Using Data for Learning and Adapting

Weekly/biweekly meetings	To monitor and track progress against the work plan and discuss any implementation issues, weekly/bi-weekly meetings will serve as an ongoing forum for updating program staff on activities completed and achievements made against targets.
Deep-dive technical pause-and-reflect meetings	We will hold periodic pause-and-reflect efforts as project-wide reviews or focus on specific regions, provinces, or health zones to analyze results of major technical areas, identify lessons learned, and develop specific actions plans.
Quarterly progress meetings and reporting	Quarterly performance reviews and quarterly implementing partners' coordination meetings, including development and submission of PSHPA quarterly activity progress reports in alignment with the contractual reporting timelines.
Semi-annual progress meetings and reporting	Semi-annual and cumulative performance reviews, including development and submission of an annual activity report, and participation in USAID/Benin portfolio review processes.
Annual work planning	Annual consultative, results-oriented work planning will incorporate reviews to reflect on experiences and lessons to date. We will use performance data to plan ahead and assess the expected contributions of all proposed annual work plan activities to the PSHPA results framework.

PSHPA will disseminate results and findings in the following ways as described in Table 4.

Table 4. Dissemination Forums

Feedback and evidence-based planning at all levels	The PSHPA work planning and review cycle will ensure adequate engagement and harmonization of project technical plans with counterpart planning cycles and priorities. To enable collaboration, learning and adapting, we will coordinate with other USAID implementing partners during work planning efforts, to share information relevant to Benin PSHPA implementation plans and learn about potential synergies with other partners.
Documenting progress and achievements	We will communicate progress, lessons learned, and key findings to USAID, MoH counterparts, private sector stakeholders, and other partners (as appropriate) through monthly project reviews, quarterly reports, success stories, interim project updates, and annual work planning.
Sharing lessons learned and new evidence	The Chief of Party (CoP) and M&E Manager will coordinate with PSSP and other private sector professional bodies and industry groups and public sector stakeholders including the MoH and GoB on national dissemination of lessons learned and new evidence. This will occur through semi-annual/annual planning and review meetings, donor coordination meetings, partner coordination meetings, department level meetings, technical conferences (as appropriate), and/or other collaboration mechanisms. We will disseminate new evidence and lessons learned beyond Benin through publications and conferences, as appropriate.

Participation in technical working groups	Active participation in communities-of-practice and technical working groups such as MNCH, malaria, RH/FP and gender, and HMIS technical working groups at the MoH, as well as engaging the private sector forums (PSSP and other private sector professional bodies and industry groups).

5. Roles, Responsibilities, and Schedule

5.1 Roles and Responsibilities

Table 5 details the role and responsibility of each actor involved in the execution of AMELP tasks. Specifically, it outlines those who are responsible, accountable, consulted, and informed (RACI) as necessary to each task.

- R - Responsible: Those responsible for the performance of the task. There should be exactly one person with this assignment for each task.
- A - Accountable: Those who are held accountable for the completion of the task.
- C - Consulted: Those whose opinions and feedback are sought after but who are not required to respond.
- I - Informed: Those who must be kept up-to-date on progress.

Table 5: Roles and Responsibilities (RACI Chart)

Action	Field Office M&E Manager	Home office RME team	Technical program team, including partners	Chief of Party	In-country stakeholders (e.g. MoH, PSSP)	USAID mission
Develop/revise ToC and Results Framework (RF)	R	A	C	A	I	C
Develop/revise indicator table	R	A	C	A		C
Develop/revise learning plan	R	A	C	A		I
Develop/revise PIRS	R	A	C	C		C
Conduct periodic integrated Data Quality Assurance (iDQA)	R	A	C	C		I
Convene and facilitate learning meetings and reviews	R	A	A	A	I	I
Report to USAID	R	A	C	A	I	I

Table 6 below shows the monitoring and evaluation reports due to USAID, their frequency of transmission and a brief description of the content

Table 6: Schedule of Monitoring, Evaluation, and Learning reports to USAID

Report	Frequency	Transmission to USAID	Description of Content	Responsible
Performance reports	Quarterly	Quarterly	This report will contain an analysis of planned versus actual project indicators during the reference period. It will also include justification for any variance and recommendations to improve performance.	M&E Manager and Chief of Party (CoP)
Gender assessment	Year 1	Year 1	The report will provide analysis of literature review findings and key informant interviews and suggest, based on discussions conducted with key stakeholders, the way forward for gender sensitive activities and results.	Gender and Youth Specialist, M&E Manager and CoP
Youth assessment	Year 1	Year 1	The report will provide an analysis of literature review findings and key informant interviews and suggest, based on discussions conducted with main stakeholders, recommendations to increase consideration of youth in activities and results.	Gender and Youth Specialist, M&E Manager and CoP
Annual progress report	Annually	Annually	This report will contain an analysis of planned versus actual project indicators during the reference period. It will also include justification for any variance and recommendations to improve performance.	M&E Manager and CoP

6. Resources

M&E direct support (field and headquarters) for monitoring, evaluation and learning is approximately 2.8% of the budget. This includes all AMELP activities, convening meetings for learning activities, and oversight of data-related tasks.

Annex I: Indicator Summary Table

#	Indicator	Baseline (2018)	Targets						Data Source / Collection Method	Reporting Frequency
			Y1	Y2	Y3	Y4	Y5	LOP		
Purpose: Increase the use of high-impact RMNCH services and products delivered by the private sector nationwide										
A.1	% of women giving birth who received uterotonics in the third stage of labor *‡[3,4] (HL.6.2-1)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	DHIS2	Annual
A.2	% of pregnant women attending antenatal clinics who receive 3 or more doses of Sulfadoxine pyrimethamine anti-malarial prophylaxis under direct observation of a health worker *[4]	9,6 % (4742/49396 2017)	22,5% (121636/540604) (2018)	N/A	N/A	N/A	N/A	N/A	DHIS2	Annual
A.3	% of babies receiving postnatal care within two days of childbirth in USG supported program[5]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	DHIS2	Annual
A.4	% of USG-assisted service delivery sites providing family planning counseling and/or services (HL.7.1-2) [6]	N/A	N/A	N/A	N/A	N/A	N/A	N/A	DHIS2	Annual
Result 1: Expanded volume of quality, high impact RMNCH services delivered by private sector providers										
B.1	# of children under-five with suspected malaria who received treatment with Artemisinin Combination Therapy (ACTs)*	746,921 (2017)	N/A	TBD	TBD	TBD	TBD	TBD	DHIS2	Annual
B.2	# of cases of child diarrhea declared in United States Government (USG)-assisted programs ‡	106,707 (2017)	N/A	TBD	TBD	TBD	TBD	TBD	DHIS2	Quarterly
IR 1.1: Significantly increased number of registered private facilities and licensed providers										
1.1.1	# of private health facilities registered	0	25	75	275	275	150	800	Project records / MoH data	Quarterly
1.1.2	# of deregulation meetings between GoB and stakeholders	0	2	2	1	0	0	5	Project records / Meeting minutes	Quarterly
1.1.3a	# of private health facilities trained in service delivery	0	25	75	275	275	100	750	Project records / Training attendance sheets	Quarterly
1.1.3b	# of private health facilities trained in administration and business strategy, and management by professional associations	0	25	75	275	275	100	750	Project records / Trainee and HF	Quarterly

									participation list	
1.1.4	# of innovative financing strategies accessible to private sector health facilities identified	0	3	0	0	0	0	3	Project records	Quarterly
1.1.5	# of private health providers supported in obtaining a license	0	25	75	150	225	225	700	Project records / Trainee participation list / Verified license #	Quarterly
1.1.6	% of female participants in USG-assisted programs designed to increase access to productive economic resources‡ (PPR indicator, code GNDR-2)	0	12 % (3/25)	20% (15/75)	40% (110/275)	25% (69/275)	30% (30/100)	30% (225/750)	Project records / Trainee participation list	Quarterly
	IR 1.2: Increased proportion of registered private health facilities with accredited RMNCH services									
1.2.1	70% of registered non-accredited private health facilities receiving quarterly accreditation visits	0	40%(10/25)	50% (50/100)	60% (225/375)	70% (455/650)	70% (560/800)	70% (560/800)	Completed accreditor site visit report / Project records	Quarterly
1.2.2	35 % of registered private facilities accredited (after completion of 2 years of visits)	0	0% (0/25)	0% (0/100)	12% (44/375)	25% (164/650)	35% 283/800	35% (283/800)	Completed accreditor site visit report / Project records	Annual
1.2.3	# of providers that received on-the-job training on high-impact RMNCH services	0	100	200	350	425	425	1500	Project records /	Quarterly

[3] The following symbols illustrate the source of each indicator: * = Benin PMP indicators; ‡ = USAID PPR (Standard Foreign Assistance) indicator. For impact indicators where we will be reporting on performance based on DHIS2 inputs, we have put "N/A" to indicate that the information is not currently available pending revision of HMIS tools.

[4] While our aim is to contribute to improvements in impact indicators 1- 2 in supported private sector health facilities, PSHPA will only influence performance indirectly through our focus on registration, accreditation, licensing, training, and advocacy activities. In addition, reporting for these impact indicators will be dependent on the availability of the data in DHIS2.

[5] This USAID indicator will be measured using data from the available, though different, DHIS2 indicator: Number of newborns expected to be followed at least twice during the first week of life.

[6] Pending availability of DHIS2 disaggregation by type of service.

									Trainee and HF participation list	
1.2.4	# of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations‡ (PPR indicator, code GNDR-8)	N/A	200	350	400	350	200	1500	Project records / Trainee participation list	Annual
1.2.5	% of USG-assisted private sector providers that offer quality PIHI services *	N/A	10% (10/100)	15% (45/300)	20% (130/650)	25% (269/ 1075)	35% (525/ 1500)	35% (525/ 1500)	Project Records / Integrated supervision checklist	Annual
	IR 1.3: Increased proportion of registered private health facilities routinely reporting on high-impact RMNCH services into the national HMIS									
1.3.1	50% of registered private health facilities supervised at least once by the MoH in past 6 months	0	20% (5/25)	30% (30/100)	40% (150/375)	45% (290/650)	50% (400/800)	50% (400/ 800)	Project Records / Completed supervision checklist	Semi-annual
1.3.2	50% of registered private health facilities reporting to HMIS on quarterly basis	N/A	15% (4/25)	20% (20/100)	25% (95/375)	35% (225/650)	50% (400/ 800)	50% (400/800)	MoH HMIS / DHIS2 / Project records	Quarterly
Result 2: Increased availability of affordable and quality health products through private sector channels										
	IR 2.1: Increased volume / gross unit sales of quality key RMNCH products in the private sector at the department level									
2.1.1	% increase (from baseline) in unit volume of tracer RMNCH products	TBD	5%	10%	15%	25%	35%	35%	Project records / Routine market data collection	Semi-annual
2.1.2	% of USG-supported health zones using health information data for decision making*	TBD	80% (6/7)	100% (7/7)	90% (31/34)	95% (32/34)	95% (32/34)	95% (32/34)	Project records / Planning and budget meeting minutes	Annual

2.1.3	% of USG-supported service delivery points and district warehouses with no stock-outs of specific tracer drugs or commodities[7]	TBD	6% (1/16)	10% (6/57)	15% (39/259)	20% (98/489)	25% (149/594	25% (149/594)	Project records / Planning and budget meeting minutes	Annual
2.1.4	Average stock out rate of contraceptive commodities at family planning service delivery points	TBD	16% (2/10)	12% (6/50)	9.2% (21/225)	7% (32/455)	2.5% (14/560)	15% (84/560)	Project records / Planning and budget meeting minutes	Annual
	IR 2.2: Improved regulatory environment for key RMNCH products									
2.2.1	# of private pharmacies or depots registered at arrondissement level	0	100	110	120	130	85	545	Project records	Annual
Result 3: Strengthened public-private engagement to promote universal RMNCH outcomes										
	IR 3.1: Increased leadership, management and governance capacity of the Platform									
3.1.1	% increase (from baseline) in Platform resource base	1,000,000	N/A	5% (1,050,000/1,000,000)	20% (1,200,000/1,000,000)	30% (1,300,000/1,000,000)	50% (1,500,000/1,000,000)	50% (1,500,000/1,000,000)	Platform records	Annual
3.1.2	# of associations that join the Platform as new members	0	N/A	1	2	3	4	10	Project records / Members list	Annual
	IR 3.2: Annual landscape of Benin's private health care regulations produced									
3.2.1	Annual documentation of Benin regulatory landscape developed	N/A	N/A	1	1	1	1	4	Project record/Landscape doc	Annual
Result 4: Innovative, successful, private sector models are identified, piloted and applied										
	IR 4.1: At least one innovative, successful private sector model applied									
4.1.1	# of innovative, successful private sector models piloted	N/A	0	1	0	0	0	1	Project records / COR verified	Annual
4.1.2	# of innovative, successful private sector models applied	N/A	0	0	1	1	1	3	Project records / COR verified	Annual

[7] Calculation is based on the number of facilities registered per year (1.1.1) plus number of HZs PSHPA works in per year (see 2.1.2) for denominator. Denominator each year is as follows: Y1: 25+6=31; Y2: 75+7=82; Y3: 275+31=306; Y4: 275+32=307; Y5: 150+32=182

Annex II: Indicator Reference Sheets

This section provides the Performance Indicator Reference Sheets (PIRS) to illustrate the clear definitions of proposed indicators, justifications of their utility, means of verification, data sources and collection methodologies to establish sound data management procedures for tracking and reporting.

PSHPA Performance Indicator Reference Sheet – Indicator A.1
Result Measured: Increase the use of high-impact RMNCH services and products delivered by the private sector nationwide
Name of indicator (HL.6.2-1)**:** % of women giving birth who received uterotonics in the third stage of labor
DESCRIPTION
Definition: Number of women who gave birth in the last year who received uterotonics in the third stage of labor (OR immediately after birth) supplied by a USG-assisted program or with assistance of a health worker trained by a USG-assisted program. Uterotonics could include oxytocin or misoprostol. Uterontonics represent one element of AMTSL. Numerator: Number of women who gave birth in the last year who received uterotonics in the third stage of labor (OR immediately after birth) supplied by a USG-assisted program or with assistance of a health worker trained by a USG-assisted program Denominator: Number of women who gave birth in the last year by a USG-assisted program or with assistance of a health worker trained by a USG-assisted program
Unit of Measure: Percentage of women
Disaggregated by: Public, Private
Rationale or justification for indicator: Increase understanding of impact of private providers on maternal health outcomes in Benin over the life of the project.
PLAN FOR DATA COLLECTION
Data Source: DHIS2
Method of Data Collection and Construction: The numerator of the indicator is in the DHIS 2 yet and is feel by PHF but the denominator is missing in general for PHF. PSHPA staff is working with the MoH to improve data collection on the denominator in DHIS 2. If successful, PSHPA anticipates the following data collection and entry processes: data on this indicator would be collected by health workers at health facilities on a daily basis through HMIS standardized documents and entry in DHIS 2. Data would then be compiled in monthly reports by the health center in-charge / “Chef-Postes” and transmitted to the health zone.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: PSHPA would only be able to report on this indicator if successfully integrated into DHIS2 and data is reliably available.

PSHPA Performance Indicator Reference Sheet – Indicator A.2
Result Measured: Increase the use of high-impact RMNCH services and products delivered by the private sector nationwide
Name of indicator: % of pregnant women attending antenatal clinics who receive 3 or more doses of Sulfadoxine pyrimethasmin anti-malarial under direct observation of a health worker
DESCRIPTION
Definition: Out of the total number of pregnant women attending their first antenatal clinic visits, those who receive 3 or more doses of Sulfadoxine pyrimethasmin anti-malarial (as recommended) under direct observation by a health worker. Numerator: Number of pregnant women attending their first antenatal clinic visits who receive 3 or more doses of Sulfadoxine pyrimethasmin anti-malarial under direct observation by a health worker Denominator: Total number of pregnant women attending their first antenatal clinic visits
Unit of Measure: Percentage Value is specific to the reporting frequency and non-cumulative
Disaggregated by: Type of HF (private, public) and Department
Rationale or justification for indicator: Increase understanding of impact of private providers on maternal health outcomes in Benin over the life of the project.
PLAN FOR DATA COLLECTION
Data Source: DHIS2
Method of Data Collection and Construction: This indicator is in the DHIS 2 yet. The following data collection and entry processes is: data on this indicator is collected by health workers at health facilities on a daily basis through HMIS standardized documents. Data are then be compiled in monthly reports by the health center in-charge / "Chef-Postes" entry into DHIS 2 and transmitted to the health zone.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: PSHPA would only be able to report on this indicator if successfully integrated into DHIS2 and data is reliably available.

PSHPA Performance Indicator Reference Sheet – Indicator A.3
Result Measured: Increase the use of high-impact RMNCH services and products delivered by the private sector nationwide
Name of indicator: % of babies receiving postnatal care within two days of childbirth in USG supported program
DESCRIPTION:
Definition: The percent of newborns attended by a health care provider during the first 48 hours following birth. Numerator: # of newborns attended during by a health care provider during the first 48 hours following birth Denominator: Total # of live births
Unit of Measure: Percentage Value is specific to the reporting frequency and non-cumulative
Disaggregated by: Type of HF (private, public) and Department
Rationale or justification for indicator: Increase understanding of impact of private providers on child health outcomes in Benin over the life of the project.
PLAN FOR DATA COLLECTION
Data Source: DHIS2
Method of Data Collection and Construction: PSHPA staff is working with the MoH to add this indicator to the DHIS2. If successful, PSHPA anticipates the following data collection and entry processes: data on this indicator would be collected by health workers at health facilities on a daily basis through HMIS standardized documents. Data would then be compiled in monthly reports by the health center in-charge / "Chef-Postes" and transmitted to the health zone where entered into the DHIS2.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: PSHPA would only be able to report on this indicator if successfully integrated into DHIS2 and data is reliably available.

PSHPA Performance Indicator Reference Sheet – Indicator A.4
Result Measured: Increase the use of high-impact RMNCH services and products delivered by the private sector nationwide
Name of indicator (HL.7.1-2) : % of USG-assisted service delivery sites providing family planning counseling and/or services
DESCRIPTION
Definition: USG-assisted: Funded with congressionally-earmarked FP funds for any kind of assistance. Service Delivery Sites: Clinics, hospitals, facilities (government, private or NGO/FBO), pharmacies, and/or social marketing sales points. Does not include community health workers (CHWs). FP counseling: FP information and/or FP counseling provided in the context of a visit with a FP service provider. FP Services: Provision of FP methods and or FP referrals Numerator: Number of USG-assisted service delivery sites providing Family Planning (FP) information and/or services. Denominator: Number of Service Delivery Sites planned to receive USG assistance over life of project.
Unit of Measure: Percentage Value is specific to the reporting frequency and non-cumulative
Disaggregated by: Type of HF (private, public) and Department
Rationale or justification for indicator: Increase understanding of impact of private providers on family planning outcomes in Benin over the life of the project.
PLAN FOR DATA COLLECTION
Data Source: DHIS2
Method of Data Collection and Construction: This indicator is not yet in the DHIS2. The following data collection and entry processes is: data on this indicator is collected by health workers at health facilities on a daily basis through HMIS standardized documents. Data are then compiled in monthly reports by the health center in-charge / "Chef-Postes", entry into DHIS2 and transmitted to the health zone.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: PSHPA would only be able to report on this indicator if successfully integrated into DHIS2 and data is reliably available.

PSHPA Performance Indicator Reference Sheet – Indicator B.1
Result Measured: Expanded volume of quality, high impact RMNCH services delivered by private sector providers
Name of indicator: # of children under-five with suspected malaria who received treatment with ACTs
DESCRIPTION
Definition: Number of children below five years of age who had symptoms of malaria and received treatment with ACTs within 24 hours of onset of malaria symptoms.
Unit of Measure: Number Value is specific to the reporting frequency and non-cumulative
Disaggregated by: Type of HF (private, public) and Department, Sex
Rationale or justification for indicator: Increase understanding of impact of private providers on child health outcomes in Benin over the life of the project.
PLAN FOR DATA COLLECTION
Data Source: DHIS2
Method of Data Collection and Construction: This indicator is in the DHIS 2 yet. The following data collection and entry processes is: data on this indicator is collected by health workers at health facilities on a daily basis through HMIS standardized documents. Data are then compiled in monthly reports by the health center in-charge /"Chef-Postes" entry into DHIS 2 and transmitted to the health zone.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: PSHPA would only be able to report on this indicator if successfully integrated into DHIS2 and data is reliably available.

PSHPA Performance Indicator Reference Sheet – Indicator B.2
Result Measured: Expanded volume of quality, high impact RMNCH services delivered by private sector providers
Name of indicator (HL.6.6-1**):** # of cases of child diarrhea declared in USG-assisted programs
DESCRIPTION
Definition: Proxy for the number of cases of child diarrhea treated in USG-assisted programs, based on what data PSHPA is able to collect from DHIS2
Unit of Measure: Number Value is specific to the reporting frequency and non-cumulative
Disaggregated by: Type of HF (private, public) and Department, Sex
Rationale or justification for indicator: Increase understanding of impact of private providers on child health outcomes in Benin over the life of the project.
PLAN FOR DATA COLLECTION
Data Source: DHIS2
Method of Data Collection and Construction: This indicator is in the DHIS 2 yet. The following data collection and entry processes is: data on this indicator is collected by health workers at health facilities on a daily basis through HMIS standardized documents. Data are then compiled in monthly reports by the health center in-charge/"Chef-Postes, entry into DHIS 2 and transmitted to the health zone.
Reporting Frequency: Quarterly
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: PSHPA would only be able to report on this indicator if successfully integrated into DHIS2 and data is reliably available

PSHPA Performance Indicator Reference Sheet – Indicator 1.1.1
Result Measured: IR 1.1 Significantly increased number of registered private facilities and licensed providers
Name of indicator: # of private health facilities registered
DESCRIPTION
Definition: The total number of private health facilities that have been registered with the MoH and have verified registration numbers as a result of PSHPA technical assistance. Registered: Has authorization as a private health facility to operate
Unit of Measure: Number of private health facilities registered with verified registration numbers
Disaggregated by: Zone (Urban, Rural) and Department
Rationale or justification for indicator: Increase understanding of impact of project activities on the registration of private providers and facilities.
PLAN FOR DATA COLLECTION
Data Source: Project records / MoH
Method of Data Collection and Construction: The list of private health facilities with verified registration numbers will be collected from the MoH.
Reporting Frequency: Quarterly
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: N/A

PSHPA Performance Indicator Reference Sheet – Indicator 1.1.2
Result Measured: IR 1.1 Significantly increased number of registered private facilities and licensed providers
Name of indicator: # of deregulation meetings between GoB and stakeholders
DESCRIPTION
Definition: This indicator measures the total number of meetings coordinated by PSHPA about deregulation between GoB and stakeholders (PSSP, ARCH, MoH, CNLS-TP, and other GoB commissions interested in the private health sector).
Unit of Measure: Number of meetings
Disaggregated by: Department
Rationale or justification for indicator: Increase understanding of impact of project activities on the regulatory environment for private providers in Benin.
PLAN FOR DATA COLLECTION
Data Source: Project records / Meeting minutes
Method of Data Collection and Construction: The project will tally the number of deregulation meetings held using the project's meeting log and meeting minutes.
Reporting Frequency: Quarterly
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 1.1.3a
Result Measured: IR 1.1 Significantly increased number of registered private facilities and licensed providers
Name of indicator: # of private health facilities trained in service delivery
DESCRIPTION
Definition: This indicator provides the total count of private health facilities whose representatives participated in RMNCH service delivery trainings conducted by PSHPA. Only facilities whose representatives were present throughout the duration of the training and participated in the pre- and post-testing will be counted.
Unit of Measure: Number of private health facilities
Disaggregated by: Zone (Urban, Rural), Department
Rationale or justification for indicator: Increase understanding of impact of project activities on substandard/uneven quality of services in the private sector.
PLAN FOR DATA COLLECTION
Data Source: Project records / Training attendance sheets
Method of Data Collection and Construction: Training participant attendance data will be reviewed by the project to derive the list of private health facilities that participated in service delivery training, disaggregated by zone, and department.
Reporting Frequency: Quarterly
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 1.1.3b
Result Measured: IR 1.1 Significantly increased number of registered private facilities and licensed providers
Name of indicator: # of private health facilities trained in administration and business strategy, and management by professional associations
DESCRIPTION
Definition: This indicator provides the total count of private health facilities whose representatives participated in trainings in administration and business strategy, and management conducted by professional associations such as the Association of Small and Medium Enterprises (ANMPE) as a result of PSHPA technical assistance. Only facilities whose representatives were present throughout the duration of the training and participated in the pre- and post-testing will be counted.
Unit of Measure: Number of private health facilities
Disaggregated by: Zone (Urban, Rural), Department, Sex
Rationale or justification for indicator: Increase understanding of impact of project activities on business skills among private providers.
PLAN FOR DATA COLLECTION
Data Source: Project records / Trainee and HF participation list
Method of Data Collection and Construction: Training participant attendance data will be routinely collected from professional associations and saved as part of project records. Annually, this data will be reviewed by the project to derive a list of private health facilities that participated in administration and business strategy, and management training, disaggregated by zone, and department. This data will be collected for participants who were present throughout the duration of the training and participated in the pre- and post-testing.
Reporting Frequency: Quarterly
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 1.1.4
Result Measured: IR 1.1 Significantly increased number of registered private facilities and licensed providers
Name of indicator: # of innovative financing strategies accessible to private sector health facilities identified
DESCRIPTION
Definition: This indicator provides the total count of innovative financing strategies available or offered, to private sector health facilities that were identified by PSHPA. Innovative financing strategies enhance the private sector health facility's capacity to offer high-impact RMNCH services. Examples include loans and service level agreements with GoB.
Unit of Measure: Number of strategies
Disaggregated by: None
Rationale or justification for indicator: Increase understanding of strategies PSHPA and other stakeholders can leverage to address lack of financial resources among private providers.
PLAN FOR DATA COLLECTION
Data Source: Project records
Method of Data Collection and Construction: Strategies will be documented by the project team as they are identified
Reporting Frequency: Quarterly
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 1.1.5
Result Measured: IR 1.1 Significantly increased number of registered private facilities and licensed providers
Name of indicator: # of private health providers supported in obtaining a license
DESCRIPTION
Definition: This indicator provides the total count of private health providers that received technical support through PSHPA to obtain a license. License: Authorization for a private provider to provide private health services
Unit of Measure: Number of providers
Disaggregated by: Zone (Urban, Rural), Department, Sex
Rationale or justification for indicator: Increase understanding of impact of project activities on the licensing of private providers.
PLAN FOR DATA COLLECTION
Data Source: Project records / Trainee participation list / MoH
Method of Data Collection and Construction: The project licensing training participant list data will be cross-referenced against data collected from the Regulation Service of the MoH, including: 1. List of private health providers who obtained a license 2. Private health provider license #
Reporting Frequency: Quarterly
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 1.1.6
Result Measured: IR 1.1 Significantly increased number of registered private facilities and licensed providers
Name of indicator (GNDR-2)**:** % of female participants in USG-assisted programs designed to increase access to productive economic resources
DESCRIPTION
Definition: This indicator will calculate the percentage of female participants (out of total participants) of the PSHPA supported training of private providers on ways to increase access to credit. Numerator: Number of female participants at PSHPA-supported private provider trainings on ways to increase access to credit Denominator: Total number of participants at PSHPA-supported private provider trainings on ways to increase access to credit.
Unit of Measure: Percentage Value is specific to the reporting frequency and is cumulative
Disaggregated by: Zone (Urban, Rural), and department
Rationale or justification for indicator: Increase understanding of impact of project activities on female private providers.
PLAN FOR DATA COLLECTION
Data Source: Project records / Trainee participation list
Method of Data Collection and Construction: Data will be collected from participant attendance list, including those who were present throughout the duration of the training and participated in the pre-testing and post-testing.
Reporting Frequency: Quarterly
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None
CHANGES TO INDICATOR

PSHPA Performance Indicator Reference Sheet – Indicator 1.2.1
Result Measured: IR 1.2 Increased proportion of registered private health facilities with accredited RMNCH services
Name of indicator: % of registered non-accredited private health facilities receiving quarterly accreditation visits
DESCRIPTION
Definition: Out of the total number of registered non-accredited private health facilities, the percentage of registered private health facilities that received accreditation visits during a given quarter. Visits: visits conducted by the MoH, PSHPA, or PSSP to verify the respect of private health facility standards Registered: Has authorization as a private health facility to operate Numerator: Number of registered, non-accredited private HFs receiving quarterly accredited visits Denominator: Number of registered, non-accredited private HFs
Unit of Measure: Percentage Value is specific to the reporting frequency and is cumulative
Disaggregated by: Zone (Urban, Rural) and Department,
Rationale or justification for indicator: Increase understanding of impact of project activities on accreditation of private providers.
PLAN FOR DATA COLLECTION
Data Source: Project records/Completed accreditor site visit report
Method of Data Collection and Construction: PSHPA will keep and monitor a list of registered non-accredited private health facilities that will receive quarterly accreditation site visits to ensure the provision of basic RMNCH care. We assume that facilities assessed in one year maintain their accreditation status across this cumulative measure. That is, those assessed in Year 1 will be counted in the numerator and denominator of each subsequent year.
Reporting Frequency: Quarterly
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: As a result of the MoH's recent reforms following the award of the PSHPA project, the targets related to this indicator may need to be modified.

PSHPA Performance Indicator Reference Sheet – Indicator 1.2.2
Result Measured: IR 1.2 Increased proportion of registered private health facilities with accredited RMNCH services
Name of indicator: % of registered private facilities accredited (after completion of 2 years of visits)
DESCRIPTION
Definition: Out of the total number of registered non-accredited private health facilities, the proportion of facilities that have been accredited after 2 years of visits. Registration: facility has obtained authorization by the Ministry of Health to provide healthcare to private clients. Registered: Has authorization as a private health facility to operate in Benin. Visits: visits conducted by the MoH, PSHPA, or PSSP to verify the respect of private health facility standards. Numerator: Number of registered private HFs accredited after 2 years of visits Denominator: Total number of registered non-accredited private HFs with 2 years accreditation visits.
Unit of Measure: Percentage Value is specific to the reporting frequency and is cumulative
Disaggregated by: Zone (Urban, Rural), and Department,
Rationale or justification for indicator: Increase understanding of impact of project activities on the accreditation of private facilities.
PLAN FOR DATA COLLECTION
Data Source: Project Records / Integrated supervision checklist
Method of Data Collection and Construction: Every year, based on project records, the PSHPA team will use and review integrated supervision checklists to determine the number of registered private HFs that have been accredited after completion of 2 years of site visits. We assume that facilities that are assessed in one year maintain their status across this cumulative measure. That is, those assessed in Year 1 will be counted in the numerator and denominator of each subsequent year and so forth.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: As a result of the MoH's recent reforms following the award of the PSHPA project, the targets related to this indicator may need to be modified.

PSHPA Performance Indicator Reference Sheet – Indicator 1.2.3
Result Measured: IR 1.2 Increased proportion of registered private health facilities with accredited RMNCH services
Name of indicator: # of providers that received on-the-job training on high-impact RMNCH services
DESCRIPTION
Definition: Total number of private health providers that have been trained on high-impact RMNCH services with PSHPA assistance. Only those who completed the training, based on attendance sheets, will be counted for this indicator.
Unit of Measure: Number
Disaggregated by: Department, Gender
PLAN FOR DATA COLLECTION
Data Source: Project records / Trainee and facility participation list
Method of Data Collection and Construction: Data will be collected from the participants' attendance lists at trainings and cross-referenced with project records on trainings conducted.
Reporting Frequency: Quarterly
Individual(s) Responsible: PSHPA M&E Manager
Rationale or justification for indicator: Increase understanding of impact of project activities on substandard/uneven quality of services in the private sector.
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 1.2.4
Result Measured: IR 1.2 Increased proportion of registered private health facilities with accredited RMNCH services
Name of indicator (GNDR-8)**:** # of persons trained with USG assistance to advance outcomes consistent with gender equality or female empowerment through their roles in public or private sector institutions or organizations
DESCRIPTION
Definition: The number of people that have participated in PSHPA-supported training of at least 3 hours in length and that is focused on developing or strengthening their institution's / organization's capacity to advance gender equality or female empowerment objectives. Relevant training includes stand-alone gender trainings as well as trainings where gender is integrated within a broader sector training. In the latter case, the training must include a substantial focus on gender issues (e.g., gender issues are addressed throughout the training, there is a gender module that explores the relevant gender issues in depth, etc.).
Unit of Measure: Number
Disaggregated by: Zone (Urban, Rural), Department, Gender of participant
Rationale or justification for indicator: Increase understanding of impact of project activities on gender equality and female empowerment.
PLAN FOR DATA COLLECTION
Data Source: Project records / Trainee and HF participation list
Method of Data Collection and Construction: Annually, training participant attendance data will be reviewed by the project to derive a list of private health facilities that participated in service delivery training, disaggregated by zone, department, and gender of representative participant(s). This data will be collected for participants who were present throughout the duration of the training and participated in the pre- and post-testing.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 1.2.5
Result Measured: IR 1.2 Increased proportion of registered private health facilities with accredited RMNCH services
Name of indicator: % of USG-assisted private sector providers that offer quality PIHI services*
DESCRIPTION
Definition: Out of the total number of private sector providers that received on-the-job training on high-impact RMNCH services by PSHPA (Indicator 1.2.3), the percentage that offer quality PIHI services (Benin's package of high impact interventions) Numerator: Number of private sector providers that received on-the-job training on high-impact RMNCH services by PSHPA that offer quality PIHI services Denominator: Total number of private sector providers that received on-the-job training on high-impact RMNCH services by PSHPA.
Unit of Measure: Percentage Value is specific to the reporting frequency and is cumulative
Disaggregated by: Zone (Urban, Rural), and Department, sex.
Rationale or justification for indicator: Increase understanding of impact of project activities on PIHI services in the private sector.
PLAN FOR DATA COLLECTION
Data Source: Project Records / Integrated supervision checklist
Method of Data Collection and Construction: Every year, based on project records, the PSHPA team will use and review integrated supervision checklists to determine the number of USG-assisted private sector providers and the subset of those that offer quality PIH services during that year. We assume that providers that are assessed in one year maintain their status across this cumulative measure. That is, those assessed in Year 1 will be counted in the numerator and denominator of each subsequent year.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 1.3.1
Result Measured: IR 1.3 Increased proportion of registered private health facilities routinely reporting on high-impact RMNCH services into the national HMIS
Name of indicator: % of registered private health facilities supervised at least once by the MoH in past 6 months
DESCRIPTION
Definition: This indicator measures the percentage of all registered private health facilities that received at least one supervision visit by a MoH representative in the past 6 months. Registered: Has authorization as a private health facility to operate Numerator: Number of registered private HFs that received at least 1 MoH supervision visit in past 6 months Denominator: Total number of registered private HFs.
Unit of Measure: Percentage Value is specific to the reporting frequency and is cumulative
Disaggregated by: Zone (Urban, Rural), and Department,
Rationale or justification for indicator: Increase understanding of impact of project activities on quality of services in the private sector.
PLAN FOR DATA COLLECTION
Data Source: Project Records / Completed supervision checklist
Method of Data Collection and Construction: The project will review project records on number of registered private HFs and will collect data on the number of said facilities that has received at least 1 supervision visit by the MoH in the previous 6 month of that year. We assume that HFs that are assessed in one year maintain their status across this cumulative measure. That is, those assessed in Year 1 will be counted in the numerator and denominator of each subsequent year.
Reporting Frequency: Semi-annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: As a result of the MoH's recent reforms following the award of the PSHPA project, the targets related to this indicator may need to be modified.

PSHPA Performance Indicator Reference Sheet – Indicator 1.3.2
Result Measured: IR 1.3 Increased proportion of registered private health facilities routinely reporting on high-impact RMNCH services into the national HMIS
Name of indicator: % of registered private health facilities reporting to HMIS on quarterly basis
DESCRIPTION
Definition: Out of all registered private health facilities, the percentage that are submitting quarterly reports to the HMIS through DHIS2. Registered: Has authorization as a private health facility to operate Numerator: Number of registered private HFs reporting to HMIS quarterly Denominator: Total number of registered private HFs.
Unit of Measure: Percentage Value is specific to the reporting frequency and is cumulative
Disaggregated by: Zone (Urban, Rural), and Department
Rationale or justification for indicator: Increase understanding of impact of project activities on availability and use of private health sector data in the HMIS.
PLAN FOR DATA COLLECTION
Data Source: MoH HMIS / DHIS2 / Project records
Method of Data Collection and Construction: All private health facilities will have access to enter data in DHIS2 as soon as they are registered. The list of private health facilities reporting into the system will be generated from DHIS2. We assume that HFs that are assessed in one year maintain their status across this cumulative measure.
Reporting Frequency: Quarterly
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: As a result of the MoH's recent reforms following the award of the PSHPA project, the targets related to this indicator may need to be modified.

PSHPA Performance Indicator Reference Sheet – Indicator 2.1.1
Result Measured: IR 2.1 Increased volume / gross unit sales of quality key RMNCH products in the private sector at the department level
Name of indicator: % increase (from baseline) in unit volume of tracer RNMCH products
DESCRIPTION
Definition: Relative to the unit volume of available tracer RMNCH products at baseline, the percentage increase in unit volume of quality key RMNCH products in the private sector. Unit volume: number of units Tracer RMNCH products: Products IQVIA can currently track in Benin include ACTs, sulfadoxine-pyrimethamine, injectable artesunate, vaccines, ORS, zinc tablets, water purification tablets, hormonal contraceptives and emergency contraceptives. Numerator: Actual unit volume of tracer RMNCH products less the baseline unit volume of tracer RMNCH products Denominator: Baseline unit volume of tracer RMNCH products
Unit of Measure: Percentage Value is specific to the reporting frequency and is cumulative
Disaggregated by: Product, Zone (Urban, Rural), and Department
Rationale or justification for indicator: Increase understanding of impact of project activities on availability of RMNCH in the private sector.
PLAN FOR DATA COLLECTION
Data Source: IQVIA and MoH, donor and international organization commodity databases
Method of Data Collection and Construction: The project will contract IQVIA to obtain monthly wholesaler data feeds of RMNCH commodities including ACTs, sulfadoxine-pyrimethamine, injectable artesunate, vaccines, ORS, zinc tablets, water purification tablets, hormonal contraceptives and emergency contraceptives. This will provide national-level data divided into eight regions for [8] of 13 products of interest for USAID for pharmacy sales. The project will triangulate this information with commodity information from the MoH (DSME, SNIGS, and DNPS), donors and private sector organizations.
Reporting Frequency: Semi-annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 2.1.2
Result Measured: IR 2.1 Increased volume / gross unit sales of quality key RMNCH products in the private sector at the department level
Name of indicator: % of USG-supported health zones using health information data for decision making
DESCRIPTION
Definition: Out of all health zones, the percentage that use health information to guide decision-making. Health information for this indicator: market data Decision making for this indicator: quantification, budget, policy and/or programmatic monitoring Numerator: Number of participating health zones that are using market data for quantification, budget, policy and/or programmatic monitoring Denominator: All participating health zones
Unit of Measure: Percentage Value is specific to the reporting frequency and is cumulative
Disaggregated by: Zone (Urban, Rural), and Department
Rationale or justification for indicator: Increase understanding of impact of project activities on availability and use of private health sector data in the HMIS.
PLAN FOR DATA COLLECTION
Data Source: Project records / Reports from MoH/DPMED attesting that GoB health zones contributing to HMIS are using market data for quantification, budget, policy and/or programmatic monitoring
Method of Data Collection and Construction: Data will be gathered through meeting reports on use of health information data for decision making, including meeting reports for dissemination of IQVIA data
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 2.1.3
Result Measured: IR 2.1 Increased volume / gross unit sales of quality key RMNCH products in the private sector at the department level
Name of indicator: % of USG-supported service delivery points and district warehouses with no stock-outs of specific tracer drugs or commodities
DESCRIPTION
Definition: Out of the total number of private sector service delivery points receiving accreditation visits and district warehouses, the proportion that have had no stock-outs of specific tracer drugs or commodities. Specific tracer drugs or commodities for this indicator include ACTs, sulfadoxine-pyrimethamine, injectable artesunate, vaccines, ORS, zinc tablets, water purification tablets, hormonal contraceptives and emergency contraceptives. Numerator: Number of registered private sector service delivery points and district warehouses that have had no stock-outs of specific tracer drugs or commodities Denominator: Total number of private sector service delivery points receiving accreditation visits per year plus district warehouses in focus regions of PSHPA per year.
Unit of Measure: Percentage Value is specific to the reporting frequency and is cumulative
Disaggregated by: Type of structure (Service delivery point, District Warehouse), Zone (Urban, Rural), and Department
Rationale or justification for indicator: Increase understanding of impact of project activities on availability of RMNCH products in the private sector.
PLAN FOR DATA COLLECTION
Data Source: Project records, compiled during accreditation visits in the 4th quarter.
Method of Data Collection and Construction: Data will be gathered as part of the accreditation visits through an accreditation checklist.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 2.1.4
Result Measured: IR 2.1 Increased volume / gross unit sales of quality key RMNCH products in the private sector at the department level
Name of indicator: Average stock out rate of contraceptive commodities at family planning service delivery points
DESCRIPTION
Definition: The average percentage of private health facilities receiving accreditation visits by PSHPA stocked out, by contraceptive commodity FP tracer product, on the day of the accreditation visit in Q4 of the workplan year. Numerator: Number of registered private HFs supported by PSHPA that are stocked out of contraceptive commodities on the day of the accreditation visit in Q4 of the workplan year. Denominator: Total number of private sector service delivery points receiving accreditation visits per year.
Unit of Measure: Percentage Value is specific to the reporting frequency and is cumulative
Disaggregated by: Zone (Urban, Rural), Department, FP tracer product
Rationale or justification for indicator: Increase understanding of impact of project activities on availability of RMNCH products at private health facilities.
PLAN FOR DATA COLLECTION
Data Source: Project records, compiled during accreditation visits in the 4th quarter.
Method of Data Collection and Construction: Data will be gathered as part of the accreditation visits through an accreditation checklist.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: In order to calculate this indicator, PSHPA will need stock out rate data for each contraceptive commodity product.

PSHPA Performance Indicator Reference Sheet – Indicator 2.2.1
Result Measured: IR 2.2 Improved regulatory environment for key RMNCH products
Name of indicator: # of private pharmacies or depots registered at arrondissement level
DESCRIPTION
Definition: At the level of the arrondissement, the number of registered private pharmacies or registered private depots Registered: Has authorization as a private health facility to operate
Unit of Measure: Number
Disaggregated by: Department, arrondissement and facility type (pharmacy, depot)
Rationale or justification for indicator: Increase understanding of impact of project activities on the registration of private pharmacies and/or depots.
PLAN FOR DATA COLLECTION
Data Source: Project records / Business case presentation
Method of Data Collection and Construction: PSHPA will review project and MoH records to measure this indicator, disaggregated by Department, arrondissement and facility type (pharmacy, depot).
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: As a result of the MoH's reforms following the award of the PSHPA project, the MoH's Pharmacy Directorate conducted a new "carte pharmaceutique." Once the MoH approves the "carte pharmaceutique" we will adjust our targets to account for this available data.

PSHPA Performance Indicator Reference Sheet – Indicator 3.1.1
Result Measured: IR 3.1 Increased leadership, management and governance capacity of the Platform
Name of indicator: % increase (from baseline) in Platform resource base
DESCRIPTION
Definition: Relative to the baseline level of Platform (PSSP) resources, the percent difference between PSSP's resources at the end of the year and resources at baseline. Numerator: Actual PSSP resource base less the baseline PSSP resource base Denominator: Baseline PSSP resource base
Unit of Measure: Percentage
Disaggregated by: Not Applicable
Rationale or justification for indicator: Increase understanding of impact of project activities on the PSSP's resource base.
PLAN FOR DATA COLLECTION
Data Source: Project records / Resource mobilization plan for PSSP
Method of Data Collection and Construction: Data will be provided through project reports on PSSP's resource mobilization plan development and implementation.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 3.1.2
Result Measured: IR 3.1 Increased leadership, management and governance capacity of the Platform
Name of indicator: # of associations that join the Platform as new members
DESCRIPTION
Definition: Number of new associations that join PSSP since the start of PSHPA
Unit of Measure: Number
Disaggregated by: Not Applicable
Rationale or justification for indicator: Increase understanding of impact of project activities on the ability of the PSSP to increase membership.
PLAN FOR DATA COLLECTION
Data Source: Project records / Resource mobilization plan for the PSSP
Method of Data Collection and Construction: Data will be provided by Project records through reports of resource mobilization plan development and implementation for PSSP
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 3.1.2
Result Measured: IR 3.1 Increased leadership, management and governance capacity of the Platform
Name of indicator: # of associations that join the Platform as new members
DESCRIPTION
Definition: Number of new associations that join PSSP since the start of PSHPA
Unit of Measure: Number
Disaggregated by: Not Applicable
Rationale or justification for indicator: Increase understanding of impact of project activities on the ability of the PSSP to increase membership.
PLAN FOR DATA COLLECTION
Data Source: Project records / Resource mobilization plan for the PSSP
Method of Data Collection and Construction: Data will be provided by Project records through reports of resource mobilization plan development and implementation for PSSP
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 3.2.1
Result Measured: IR 3.2 Annual landscape of Benin's private health care regulations produced
Name of indicator: Annual documentation of Benin regulatory landscape developed
DESCRIPTION
Definition: This indicator affirms whether or not the documentation of Benin regulatory landscape report was developed each fiscal year
Unit of Measure: Yes/No Yes=1, No=0
Disaggregated by: Not Applicable
Rationale or justification for indicator: Increase understanding of impact of project activities on the regulation of the private health sector.
PLAN FOR DATA COLLECTION
Data Source: Project records / Regulatory landscape report
Method of Data Collection and Construction: PSHPA will use its project records plus the final version of the annual documentation of Benin regulatory landscape report to confirm this indicator
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 4.1.1
Result Measured: IR 4.1 At least one innovative, successful private sector model applied
Name of indicator: # of innovative, successful private sector models piloted
DESCRIPTION

Definition:

The number of innovative, successful private sector health models piloted through PSHPA.
Private sector health models: models to increase private sector participation in and contribution to health service delivery. Private sector models include group practice, health enterprise funds, public-private partnerships for health and the informed push model per the PSHPA contract (see table below).
Successful: models that have been shown to work in Benin, similar countries or across global contexts

Innovative private sector models

Model	Challenges	Benefits of Model	Proposed Activities for Benin
Group practice	• PS operates on an individual basis, resulting in a "low-volume, high-unit cost, low-margin" model for service delivery • Policy environment not conducive to group practice or provider networks	ractice could improve volume of patients, pricing, and cost structure of private health facilities so services are converted into high-volume, high-quality, and low-unit cost practices.	• Assist PSSP to advocate with MoH to relax restrictions on marketing and deregulate prices. • Prepare and circulate a business case to private providers for group practice and network agreements. • Provide legal and financial advice to private providers. • Provide model partnership agreements.
Health Enterprise Fund	• Entrepreneurship and innovation in Benin are nascent, with no focus on health. • Ecosystem of support for health entrepreneurship is not well understood.	Health enterprises offer enormous potential to improve lives at scale through innovation to directly contribute to health outcomes.	• Map the health innovation ecosystem. • Facilitate workshops to encourage innovation and collaboration in addressing priority health challenges. • Offer seed funding and technical support to promising entrepreneurs, particularly youth.
Public-private Partnership for health	• Health sector not priority for partnerships	health add value to delivery of better health outcomes through promotion of synergies, collaboration and cost- effective investment.	• Identify health gaps needing attention. • Using a participatory process, develop a roadmap for health PPPs in Benin. • Facilitate contracts for service delivery, particularly in rural areas.
Informed push model	• Stock-outs of RMNCH products common and lack of market segmentation	s supply chain efficiency as dedicated supply team delivers (pushes) critical commodities to health facilities from a central/regional store instead	• Conduct rapid assessment of feasibility of informed push model in collaboration with MoH, PSSP and Global Health Supply Chain Program-

		of waiting for forecasts/orders.	Procurement and Supply Management. • -Support training of supply chain actors and development of tools.	

Unit of Measure: Number
Disaggregated by: Not Applicable
Rationale or justification for indicator: Increase understanding of innovative, tested private sector models that could contribute to increasing the role of the private health sector in Benin.
PLAN FOR DATA COLLECTION
Data Source: Project records / COR verified
Method of Data Collection and Construction: PSHPA will use project records to tally the number of innovative, successful private sector models that have been piloted through the project's technical assistance.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

PSHPA Performance Indicator Reference Sheet – Indicator 4.1.2
Result Measured: IR 4.1 At least one innovative, successful private sector model applied
Name of indicator: # of innovative, successful private sector models applied
DESCRIPTION
Definition: The number of innovative, successful private sector health models scaled up in each of the 12 departments through PSHPA technical assistance Private sector health models: models to increase private sector participation in and contribution to health service delivery. Private sector models include group practice, health enterprise funds, public-private partnerships for health and the informed push model per the PSHPA contract (see table below). Successful: models that have been shown to work in Benin, similar countries or across global contexts
Unit of Measure: One model scaled up in each department
Disaggregated by: Not Applicable
Rationale or justification for indicator: Increase understanding of innovative, tested private sector models that could contribute to increasing the role of the private health sector in Benin.
PLAN FOR DATA COLLECTION
Data Source: Project records / COR verified
Method of Data Collection and Construction: PSHPA will collect routine data on the number of innovative, successful private sector models scaled up of through the project's technical assistance, triangulating with its report on the application of one of 4 best practices on financing private sector identified and scaled up in each of 12 departments.
Reporting Frequency: Annual
Individual(s) Responsible: PSHPA M&E Manager
DATA QUALITY ISSUES
Dates of Data Quality Assessments and Name of Reviewer(s): TBD
Known Data Limitations: None

Annex III: Data Collection Instruments

The SNIGS tool C6 below collects the data essential for calculating indicators A1, A2, and A4

RAPPORT SUR LES ACTIVITES DE MATERNITE

MINISTERE DE LA SANTE

Département : .....

Zone Sanitaire : ..... Commune :..... **C6**

Nom de la formation sanitaire..... Mois de : .....20.....

TOTAL ACCOUCHEMENT...(1)=(2)+(3).....	
ACCOUCHEMENTS EUTOCIQUES (2).....	
ACCOUCHEMENTS EUTOCIQUES ASSISTES PAR UN PERSONNEL QUALIFIE.....	
ACCOUCHEMENTS DYSTOCIQUES.....(3).....	
dont	
. Césarienne.....	
. Forceps.....	
. Ventouse.....	
TOTAL DES NAISSANCES VIVANTES.....	
ENFANTS REANIMES.....	
MORTS-NES.....	
ENFANTS VIVANTS DE POIDS <2500 g.....	
GATPA.....	
HEMORRAGIE DU POST-PARTUM.....	
ECLAMPSIE.....	
AVORTEMENTS.....	
DÉCÈS MATERNELS.....	
ENFANTS REANIMES EN VAIN.....	
DECES D'ENFANT INFERIEUR A 7 JOURS.....	
FEMMES EN TRAVAIL REFEREES D'URGENCE ET ARRIVEES A L'HOPITAL.....	
HOSPITALISEES	
OBSERVEES.....	
JOURS D'HOSPITALISATION.....	
JOURS D'OBSERVATION.....	
NOMBRE DE LITS.....	
ACCOUCHEES AYANT RECU LA VITAMINE A.....	

RAPPORT SUR LA SANTE MATERNELLE ET INFANTILE

	CONSULTATION DES MERES		CONSULTATION DES ENFANTS SAINS	
	PRENATALE	POSTNATALE	0 - 11 MOIS	12 - 35 MOIS
Nouveaux (elles) Consultants (es)				
Anciens (nes) consultants (es)				
Consultants(es) total(es)				
CPN1 Standard				
CPN 4 Standard				
CPoN1				
CPoN3				
Nombre de cas de IMC < 18,5				
Nombre de cas d'insuffisance pondérale (Poids/Age)				
Nombre de cas de retard de croissance (Taille/Age)				
Nombre de cas d'émaciation (Poids/Taille)				
Enfants < 5 ans pris en charge selon PCIME				
Femmes ayant reçu FER/ ACIDE FOLIQUE				
Femmes ayant reçu TPI/SP 1				
Femmes ayant reçu TPI/SP 2				
Femmes ayant reçu TPI/SP 3				
Femmes ayant reçu la MILLD				
Nombre de grossesses à risque détectées				
Nombre de grossesse à risque non en travail d'accouchements référés				
Femmes ayant recues au moins une dose de déparasitant au cours de la grossesse				
Femmes souffrant d'anémie				
Cas de paludisme simple non testé				
Cas de paludisme simple testé positif				
Cas de paludisme grave				
Cas de décès dû au paludisme				

RAPPORT SUR L'ACCEPTATION DES METHODES CONTRACEPTIVES

ACCEPTANTES	METHODES										
	DIU	CI			CO	Implant		CU	Stérilisation	Collier	Préservatif
		Noristérat	Depo provera	Sayana press		Jadelle	Implanon				
Nouvelles acceptantes											
Anciennes acceptantes											
Acceptantes totales											

Date .....; Nom..... Signature

The PNIP1 tool of NHMIS allows collection of data to estimate a proxy indicator B1 by the number of children under five years having received a prescription of ATC REPUBLIQUE DU BENIN
Ministère de la Santé
Programme National de Lutte contre le Paludisme (PNLP)

Département ……..…… Zone sanitaire ……
Commune ……. Arrondissement…….
Formation sanitaire …….
Rapport du Mois de ……. Année …….. ….
Date de transmission du rapport vers ZS Jour__ __/ Mois __ __/Année __ __ __ __ /
Date de réception à la ZS Jour__ __/ Mois __ __/Année __ __ __ __ /

Rapport mensuel de surveillance et logistique PNLP1

Indicateurs	Dispensaire				Maternité	Total (1) + (2) + (3)	
	Moins de 5 ans (1)		5 ans et plus sans les femmes enceintes (2)		Femmes Enceintes (3)		
	Masculin	Féminin	Masculin	Féminin		Masculin	Féminin
Paludisme simple							
Cas de paludisme simple diagnostiqué cliniquement sans test							
Cas testés au TDR							
Cas testés à la GE							
Cas testé TDR positif							
Cas testés GE Positif							
Cas de paludisme simple notifié dans le registre de soins curatifs							
Nombre de cas de paludisme ayant bénéficié de prescription de CTA							
Nombre de cas de paludisme ayant eu de CTA à la pharmacie du centre							
Paludisme grave							
Cas de paludisme grave diagnostiqué cliniquement sans test							
Cas testés au TDR							
Cas testés à la GE							
Cas testés TDR positif							
Cas testés GE positif							
Paludisme grave notifié dans le registre de soins curatifs							

Décès dus au paludisme grave (testé positif)							
Décès dus au paludisme grave diagnostiqué cliniquement sans test							

Y a-t-il eu rupture de stock ***(d'au moins 1 jour) dans le mois? (encerclez la bonne réponse)***					
CTA toutes catégories	MIILD	SP	TDR	Quinine injectable	Artésunate injectable
Oui ; Non	Oui ; Non	Oui ; Non	Oui ; Non	Oui ; Non	Oui ; Non

Nom et prénom du responsable : _____

Signature _____

Nom et prénom du statisticien : _____

Signature _____