STOCKHOLM EVALUATION UNIT

MÉDECINS SANS FRONTIÈRES LÄKARE UTAN GRÄNSER

EVALUATION OF

COUFFO PROJECT, BENIN

OCTOBER 2025

This publication was produced at the request of Médecins Sans Frontières (MSF) – Brussels Operational Centre (OCB) under the direction of the Stockholm Evaluation Unit (SEU).

All evaluators engaged by SEU adhere to the SEU Ethical Guidelines for Evaluations.

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This report is a translation of the original French version, which remains the reference document. Readers are encouraged to refer to the French version, which may more accurately reflect the nuances and wording intended by the evaluation team.

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ABBREVIATIONS

ANC	Antenatal consultations
BEmONC	Basic Emergency Obstetric and Neonatal Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
COGES	Health Centre Management Committee (*Comité de Gestion)*
CNGOB	National College of Obstetrician-Gynaecologists of Benin
DDS	Departmental Directorate of Health (*Direction Départementale de la Santé*)
EVA	Exploring Values and Attitudes
FP	Family planning
HDZ	KTL Zone Hospital (Hopital de Zone)
HP	Health Promotion
IEC	Information, Education and Communication
IPC	Infection prevention and control
KII	Key informant interviews
KRQ	Key Review Questions
KTL	Klouékanmè, Toviklin and Lalo
MCZ	Health Zone Coordinating Doctor (*Médecin Coordinateur de Zone*)
MICS	UNICEF Multiple Indicator Cluster Surveys
MNH	Maternal and Newborn Health
MoH	Ministry of Health
MSC	Most Significant Change
MSF	Médecins Sans Frontières
MVC	Women leaders (also known as "*membres des volontaires communautaires*")
PNC	Postnatal consultations
QA	Quality assurance
SAC	Safe Abortion Care
SEU	Stockholm Evaluation Unit
SRH	Sexual and Reproductive Health
ToC	Theory of Change
VSX	Victims of Sexual Violence
WHO	World Health Organisation

SUMMARY

INTRODUCTION

The mid-term review of the Couffo project of Médecins Sans Frontières (MSF) in Benin, conducted by Global Health Direct for the Stockholm Evaluation Unit, aimed to analyze the relevance, effectiveness, efficiency and sustainability of the interventions carried out since 2022 in the health zone of Klouékanmè, Toviklin and Lalo. This review, conducted using a mixed and participatory methodology, combined literature review, use of routinely collected medical data, stakeholder interviews, community focus groups, and field observations. It was based on a Theory of Change co-constructed with MSF, serving as a framework for contribution analysis and the identification of critical links in the results chain. Methodological limitations include the lack of independent primary quantitative collection, the variable quality of routinely collected data, partial access to databases, and the limited geographic scope of the sample analysed.

KEY RESULTS

1. What is the general approach and what activities have been implemented in Couffo?

To address national strategic priorities in sexual and reproductive health (SRH) and maternal and newborn health (MNH) to reduce maternal morbidity and mortality, the project adopted a general approach combining clinical capacity building, improved infrastructure, provision of essential equipment, and community mobilization structured around women leaders. This dual clinical and community-based approach was seen as appropriate to achieve the multiple objectives set for the project.

Activities implemented

The Couffo project deployed a set of clinical, community and institutional actions:

- **Strengthening the provision of quality care**: ANC (1 and 4), assisted deliveries, family planning (FP), safe abortion care (SAC), care for victims of sexual violence (VSX).
- **Support in terms of infrastructure and equipment**: rehabilitation of maternity wards, installation of water towers and WATSAN/IPC equipment, supply of medical equipment (ultrasound machines, surgical and neonatal equipment, test devices, medicines and various healthcare equipment).
- **Capacity building**: monthly training and bi-monthly coaching for 12 midwives on Comprehensive Emergency Obstetric and Neonatal Care (CEmONC), Exploring Values and Attitudes (EVA), SAC, VSX, FP and infection prevention.
- **Community engagement**: establishment and training of women leaders (MVCs) in charge of awareness-raising, home visits (basic medical consultation), referral to HCs, and "whisperers" groups to influence community behaviours towards MNH and SRH.
- **Referral mechanisms**: installation of tricycles for emergency medical transport and full coverage of transport costs and care of urgent cases at the local hospital.
- **Financial and institutional support**: select free services, salary supplements, gradual integration into the institutional mechanisms of the MoH, collaboration with the Departmental Directorate of Health (DDS)/ Health Zone Coordinating Doctor (MCZ).

Adapted activities

Some components have required adjustments to local and institutional realities:

- **Gradual introduction of SAC and VSX**: preceded by advocacy and awareness-raising to reduce social and religious resistance. Due to the conscientious objection of many midwives, MSF has had to rely on a small core of volunteer providers and establish ad hoc partnerships with private clinics.
- **Medication management**: after negotiation with the authorities, MSF obtained authorization to import medicines and the stocks were integrated into the national circuit, escaping MSF's direct logistical control, which required an adaptation of coordination and monitoring.
- **Clinical training**: necessary adaptation in the face of contradictions between MSF protocols and national standards, and the need to involve more local trainers for harmonization.
- **Support cycle**: introduction of a rotating model (2 years of support per health centre), with gradual adjustment of withdrawals and integrations to take into account the actual capacity of the health centres.

Overdue activities

Other actions planned or initiated are experiencing delays or remain incomplete:

- **Institutionalization and sustainability**: weak planning by the Ministry of Health to ensure the retention of human resources and the maintenance of gains after the withdrawal of MSF.
- **Maintenance of infrastructure and equipment**: concerns about the long-term maintenance of WATSAN/IPC equipment and installed hardware.
- **Integration of trained personnel**: not systematically taken up by the authorities, which weakens the sustainability of the investment in capacity building.
- **Monitoring and evaluation systems**: still fragmented between several databases (health, HP, finance, HR, etc.), hindering the consolidation and optimal use of data.
- **Recognition and motivation of women leaders**: their volunteer status and the absence of institutional mechanisms weaken the continuity of their commitment after MSF's departure.

The introduction of the SAC and VSX components followed a phased approach, preceded by an awareness and advocacy phase to reduce resistance. While progress has been made, the provision of care remains vulnerable due to the conscientious objection widely practiced by midwives and the dependence on a small number of voluntary providers. Ad hoc partnerships with private clinics have made it possible to temporarily compensate for this deficit, but their sustainability requires a diversification of providers, harmonization of protocols with the Ministry of Health, and strengthening of legal and institutional advocacy.

2. What changes have been observed following the implementation of the project?

First, the project improved the provision of SRH and MNH services offered in MSF-supported health centres through holistic support including infrastructure, equipment, capacity building for health personnel, financial and institutional support. In addition, the project has helped to stimulate demand for these services by changing the perception of some pregnant women and women of reproductive age through community awareness and follow-up by women leaders and “whisperers”. The project contributed to the gradual evolution of community perceptions on sensitive issues such as abortion and contraception. Women leaders, selected by the communities, have played an essential role in breaking down socio-cultural barriers, disseminating reliable information and referrals to health care facilities. This strategy has resulted in better

access to information on available SRH and MNH services, a reduction in logistical and financial barriers directly limiting access to these services, and a strengthening of the health systems providing these services. The sustainability of this model still rests on a fragile foundation, in particular because of the voluntary nature of the commitment of women leaders and the absence of institutional mechanisms to guarantee the continuity of their activities after a possible withdrawal of MSF. Aware of this limitation, the project nevertheless integrated the sustainability dimension from the outset by placing a strong emphasis on community engagement, through a participatory process of selection and mobilization of women leaders. They were identified and recruited after in-depth working sessions with their communities, in order to consolidate the legitimacy of their role and strengthen local buy-in. To address the key issue of funding and empowering these initiatives, MSF has also partnered with a specialized civil society organization, Éleveurs sans Frontières, which supports women leaders in developing income-generating activities adapted to their context. This strategy aims to strengthen their capacities and diversify their livelihoods, thus creating prospects for sustainability beyond MSF's direct support.

In MSF-supported health centres, the project may have indirectly contributed to an increase in the coverage rate of ANC1, the maintenance of quality MNC services, and an increase in PNC2 in the health centres supported by the project. The improvement of these indicators seems to be correlated with the implementation of project activities. However, the data collected by the review do not clearly identify effects on the rate of ANC4 in the third trimester of pregnancy, deliveries by qualified personnel, the use of SAC or VSX services, and FP consultations for pregnant women. The results are mixed and do not show any significant change. It should also be noted that some limitations related to data quality – such as potential data entry errors, changes in data collectors or changes in the methods of calculating indicators – may have influenced these results. At the level of KTL Zone Hospital (HDZ), the review notes a decrease in the case fatality rate of direct obstetric complications and in the intra-hospital maternal mortality rate since the beginning of the project. It is difficult to attribute these changes to the project, but a few key facilitators emerged from qualitative and documentary data, including the establishment of a referral and transport system for emergency obstetric and neonatal cases, large-scale awareness raising on the importance of MNH services particularly for pregnancy follow-up, and MSF's funding of CEmONC and quality MNH services provided.

3. How can the achievements of the MSF project be preserved and sustained once the project is transferred to the Beninese authorities?

The mid-term review also identifies structural constraints that hinder the effectiveness and sustainability of the project: uneven management of referral tricycles, issues in pharmaceutical supply, rotation of MSF international mobile staff and national MoH staff, lack of systematic feedback to community structures (COGES), and difficulties in accessing certain disaggregated data for the analysis of results by the monitoring team. In addition, the retention of activities by the Ministry of Health remains a major challenge due to limited human and financial resources, which compromises the institutional capacity to maintain the gains made and underlines that the sustainability of the project's results remains fragile.

4. In what ways and for whom was the project a success? Has it been a success for MSF, the Ministry of Health (MoH), communities and patients?

The project was a success for MSF, allowing the organisation to forge close links with the MoH and local health authorities, and to pilot a community-based approach in parallel with a standard clinical approach.

For the Ministry of Health, the project has provided concrete support for strengthening the local health system: improvement of staff capacities (CEmONC, BEmONC, SAC, VSX, IPC training), provision of equipment and

medicines, targeted free care, and introduction of innovative apparatus such as referral tricycles. These elements helped to strengthen the project's alignment with national priorities and to test solutions that could be transferred to other areas.

For communities and patients, the benefits have been tangible: reduction of financial barriers through targeted free care, expanded and better access to ANC, childbirth and SRH services, improved practices for the prevention and management of obstetric emergencies, and a gradual transformation of perceptions on sensitive issues such as family planning, SAC and VSX. The commitment of women leaders and the co-construction with the COGES have strengthened confidence in the care system and fostered local ownership, despite the challenges of motivation and recognition that remain to be consolidated to ensure sustainability.

5. Is the project design relevant and appropriate to the general/specific objective of the project?

The review highlights that the project's objectives were well aligned with the context and priority needs of the intervention area, in particular to address the persistent challenges of quality and access to care in Couffo. The project built its approach around a standard MSF care package focused on maternal, newborn and child health (MNCH), while complementarily integrating sexual and reproductive health (SRH) components. This combination has made it possible to strengthen the coherence and relevance of the care offer, promoting a comprehensive and integrated approach for the benefit of the communities.

6. What opportunities can be identified to make the project more effective? What challenges remain to be solved?

The Couffo project could be more effective by consolidating an integrated monitoring and evaluation system, harmonizing protocols with the Ministry of Health and strengthening advocacy for the sustainability of the gains. However, several challenges remain: lack of continuity of trained staff, difficulties in maintaining infrastructure and equipment, socio-cultural resistance to SAC and VSX, as well as systemic limitations related to the financing, logistics and governance of the health system.

7. What lessons can be learned from the project's community engagement approach that are relevant to other OCB projects?

The community-based approach of the Couffo project shows that the involvement of women leaders and community groups is a powerful lever for increasing adherence to care, including on sensitive issues such as SAC and VSX. It emphasizes the importance of an integrated strategy, combining clinical strengthening and local mobilization, to remove social and financial barriers. Transferable lessons for OCB include: participatory selection of women leaders, co-construction with COGES, institutional recognition, and tailored incentives.

8. What lessons can be learned from the collaboration with the Ministry of Health that are relevant for other OCB projects?

Collaboration with the Ministry of Health has shown the importance of close alignment with national priorities and co-construction of interventions to strengthen both legitimacy and sustainability. Institutional delays, sometimes perceived as restrictive, have proven to be strategic opportunities to refine approaches and strengthen mutual trust.

Lessons for improving the project itself: it is necessary to further harmonize protocols with those of the Ministry, and to integrate project achievements more systematically into national plans and budgets to promote their sustainability.

Good practices already implemented: from the design, implementation and monitoring of interventions, the project has ensured early involvement of health authorities. During the first two years, MSF presented the progress of activities to the Ministry of Health every six months, allowing regular exchanges on the results achieved and the challenges encountered.

Broader lesson: it is essential to support the strengthening of the Ministry's administrative capacity in order to support the sustainability of the project. However, this area goes beyond MSF's direct mandate and requires longer-term institutional investment.

RECOMMENDATIONS FOR THE PROJECT

Faced with these findings, the review highlights a selection of priority recommendations, from a broader set developed in the full report. These recommendations are aimed at:

1. **Consolidating institutional integration and sustainability**

- Strengthen advocacy with the Ministry of Health and local authorities for the gradual integration of project gains (trained human resources, equipment, community mechanisms) into plans and budgets.
- Support the DDS, MCZ and health centres in administrative and financial management to secure continuity after MSF's withdrawal.

2. **Strengthening the quality and resilience of clinical services**

- Train all healthcare providers on key themes (MNH, SAC, VSX) and organize regular refresher sessions.
- Continue to harmonize protocols with the MoH, supporting the updating and ownership of national protocols, with the direct involvement of national trainers.
- Diversify SAC providers (private partners, local NGOs) to reduce dependence on a limited number of actors and limit the impact of conscientious objection.

3. **Strengthening community mechanisms and their recognition**

- Maintain and enhance the role of women leaders (continuous education, institutional recognition, income-generating activities via partnerships such as Éleveurs sans Frontières), while clarifying their complementarity with community health workers.
- Optimize community management mechanisms (referral tricycles, referral monitoring) and strengthen consultation with the COGES to increase their role in sustainability.

4. **Improve transition and follow-up**

- Develop operational transition planning tools, with clear and progressive milestones.
- Establish a post-intervention monitoring system (key indicators) to detect any regression after MSF's withdrawal.
- Adjust the duration of MSF's support according to the resolution of certain structural issues (salaries, sustainable funding), rather than an automatic extension of the support.

CONCLUSION

In conclusion, the Couffo project is distinguished by an integrated and relevant approach, which has led to significant progress in maternal and newborn health and sexual and reproductive health in a context that is both stable and marked by persistent structural challenges. The successes observed are based on the complementarity between reinforced clinical provision and community mobilization, but their sustainability will depend on the ability to address the critical assumptions identified, to institutionalize practices and to ensure a planned and contextualized transition to local and national actors. This review highlights how the project stands at the intersection of humanitarian action and health systems strengthening. Yet, the project's theory of change does not sufficiently define the level of ambition for results to be sustained after the project is concluded. We recommend strategic reflection on the potential of the project to serve as a catalyst for systemic change.

INTRODUCTION AND BACKGROUND

PURPOSE OF THIS REPORT

The objective of this report is to present the results of the mid-term review of the Couffo project of Médecins Sans Frontières (MSF) in Benin. It is structured as follows:

- Section 1: Analysis of the national context and the Couffo department, presentation of the MSF project, its intervention logic and the Theory of Change (ToR), as well as the limitations of the mid-term review.
- Section 2: Detailed presentation of the results of the mid-term review.
- Section 3: Synthesis of recommendations and lessons learned for the project and for other interventions of the MSF Operational Centre Brussels (OCB).
- Section 4: Conclusions.
- Appendix 1: A Theory of Change Narrative.
- Appendix 2: The Strength of Evidence Matrix.

The analyses are based on:

- A preliminary visit to Couffo.
- A thorough review of the available literature, including secondary quantitative data.
- Interviews and focus groups conducted during visits to the project sites in June 2025.

To make it easier to read, a colour code is used:

Blue boxes for **key results**
Green boxes for **recommendations to the Couffo project**
Orange boxes for **lessons learned for other OCB interventions**

Similarly, a strength of evidence badge system (the matrix of which is available in Appendix 2) is used for each key result as follows:

Strong: when there is good triangulation of data from various sources.	**Medium**: when there is some triangulation of the data or when the evidence is reported in official project documents.	**Anecdotal:** when the evidence is limited to a few respondents during interviews.

CONTEXT OF BENIN

NATIONAL CONTEXT

Maternal and infant mortality remains a major public health challenge in Benin, despite a downward trend in rates since 2001. The main causes include complications related to pregnancy and childbirth (postpartum hemorrhage), as well as childhood diseases such as malaria, respiratory infections and prematurity. The government, supported by development partners, is implementing strategies to improve the quality of care and strengthen surveillance of these deaths, recognizing that reducing these indicators is crucial for the country's long-term health and development.

In 2018, it adopted an **operational plan for the reduction of maternal and neonatal mortality**[1], through which the Ministry of Health (MoH) sets the objectives, determines the strategies to achieve them, as well as the clinical, managerial, political, legislative and other interventions required to influence maternal and neonatal mortality indicators.

In the same vein, on October 20, 2021, the Beninese parliament adopted a new legal amendment to **the 2003 law on sexual and reproductive health (SRH),**[2] expanding legal access to safe abortion through Article 17 and marking a much-needed step in addressing preventable maternal deaths and disabilities suffered by women, girls and their families due to unsafe abortion. Despite a favourable legislative framework, with a law that promotes access to abortion up to 12 weeks of pregnancy, the effective implementation of national policies seems limited. Health workers are reluctant to offer safe abortion care (SAC) because of taboos related to socio-cultural beliefs[3].

In recent years, to facilitate access to health care for the population, the government has set up the **new compulsory health insurance with the ARCH plan** (*Assurance pour le Renforcement du Capital Humain* or Insurance for the Strengthening of Human Capital). The department of Couffo is marked by the coexistence of two systems of free care. Free for certain types of care and free for the "extreme poor ARCH". However, there

[1] Operational Plan for the Reduction of Maternal and Neonatal Mortality in Benin PO-RMMN 2018 – 2022, Directorate of Maternal and Child Health – Ministry of Health (March 2018)
[2] LOIN°2U03-04nuU3MAHS200.1 Republic of Benin
[3] Sources: Preliminary interviews with the MSF coordination team and preliminary visit to the project sites.

are many challenges in implementing ARCH, and many vulnerable patients continue to be excluded from care due to lack of financial means[4].

In addition, Benin adopted the **National Community Health Policy in 2020[5].** This policy launched in 2023 aims to address the challenges involved in significantly reducing maternal, neonatal and infant morbidity and mortality by involving populations more in the management of their health, with the vision that by 2025, everyone living in Benin will have acquired skills and resources to manage their health independently in partnership with health professionals, community members and other development actors, in a more effective local health system.

An analysis of all these efforts revealed[6] that there has been no significant progress in reducing maternal and newborn mortality. The coverage levels and quality of key interventions targeting women of reproductive age, pregnant women and newborns are insufficient to produce meaningful change. The weaknesses identified relate mainly to the lack of ownership of the strategy for reducing maternal and neonatal mortality by actors at the operational and intermediate levels, the lack of qualified human resources, the fragmentation of the strategy's implementation, the weak partnership with the private sector, and the problems of coordination and monitoring/evaluation.

PROJECT CONTEXT

In Benin, the maternal mortality ratio is 518[7] deaths per hundred thousand live births and the neonatal mortality rate is 38 per thousand live births (MICS 2017-2018). In Couffo, the socio-health context demonstrates the challenges observed at the national level with critical health indicators. The maternal mortality ratio at 182.4 per hundred thousand live births, neonatal mortality rate at 30 per 1000 live births, fertility rate among 15–19-year-olds at 68%, total fertility rate at 5.6 children per woman, and unmet needs for contraception at 29.4% (MICS 2021-2022).

STRATEGIC OBJECTIVES

The Couffo project, launched by MSF in 2022 and scheduled to run until 2027, is of strategic importance to the organisation. After nearly fifteen years of absence, MSF restarted its activities in Benin to respond to maternal and neonatal health needs in Couffo and the growing challenges in the north, linked to the spread of the security crisis in the central Sahel. In addition, this context has made it essential to build strong relationships with the Beninese government. The project was an opportunity for MSF to pilot a more elaborate community engagement approach than in its usual interventions, taking advantage of the stability of the Beninese context to experiment with more comprehensive strategies.

PROGRAMMATIC OBJECTIVES

The project aims to contribute to the **reduction of maternal and neonatal morbidity and mortality in the KTL Health Zone in collaboration with the community and the strengthening of the quality of care offered at the primary and secondary levels**. In the Klouékanmé, Toviklin and Lalo Health Zone (KTL), MSF is working at the Klouékanmé Zone Hospital (HDZ) by strengthening the operating theatre, sterilisation, maternity, neonatology

[4] MSF in Benin Advocacy Strategy 2025

[5] National Community Health Policy 2020-2030, Ministry of Health (May 2020)

[6] Operational Plan for the Reduction of Maternal and Neonatal Mortality in Benin PO-RMMN 2018 – 2022, Directorate of Maternal and Child Health – Ministry of Health (March 2018)

[7] Trends in maternal mortality estimates 2000 to 2023: estimates by WHO, UNICEF, UNFPA, World Bank Group and UNDESA/Population Division. Geneva: World Health Organization; 2025. License: CC BY-NC-SA 3.0 IGO.

and laundry facilities and, at the same time, MSF is also supporting the primary health centres of Tohou, Adjahonmé, Lokogba, Toviklin and Klouékanmé.

More specifically, the project aims to strengthen the offer of services of:

1) Maternal and neonatal health (MNH) for pregnant women and newborns, such as antenatal consultations (ANCs), delivery, and postnatal consultations (PNCs) for newborns
2) Sexual and reproductive health (SRH) and family planning (FP) such as contraceptive and abortion care for women of childbearing age
3) Sexual Health for Survivors of Sexual Violence (VSX) and Gender-Based Violence as well as a mental health component under development.

To achieve this, the project adopted a multi-pronged approach through:

- **Expected Result 1**: Health promotion and SRH services in communities through women leaders
- **Expected Result 2**: Quality health care in ANC, delivery, CPoN and neonatal care, including basic psychological support and BEmONC in health centres (HCs)
- **Expected Result 3**: Quality CEmONC available at HDZ KTL
- **Expected Result 4**: Modern contraceptive care, comprehensive medical and psychosocial care of VSX survivors, and available and accessible quality safe abortion care
- **Expected Result 5**: Analysis and documentation of the impact of ARCH health insurance on access to care for the most vulnerable in KTL

To achieve these objectives, the project relied on an inclusive approach, focused on the specific needs of the most vulnerable populations. More broadly, the project aims to improve the knowledge, learning, practices and capacities of health workers and communities to foster a culture and environment conducive to the reduction of maternal and neonatal mortality and morbidity.

PROJECT IMPLEMENTATION

The start-up phase of the project, which lasted about a year, was marked by negotiations with the Beninese government, which initially seemed reluctant to host MSF. This reluctance could be linked to differences of vision, particularly on the issue of free healthcare. However, this period of negotiation allowed MSF to conduct in-depth analyses of the situation and to develop a more structured community engagement strategy, adapted to a relatively stable context, in contrast to the more unstable environments in which the organisation usually operates.

Since 2024, the project has expanded its activities by integrating safe abortion services (SAC) and support for victims of sexual violence (VSX). This evolution has broadened the scope of the project from a focus on maternal and child health to a more holistic SRH approach. Although abortion is legal in Benin, there is still reluctance among some health workers to offer these services, which led MSF to collaborate with the private clinic Grace Divine to strengthen the provision of services. In addition, a new psychosocial support component for the VSX and SAC components is being prepared and is scheduled to be rolled out in June 2025.

The SRH project started in November 2022 in health facilities, and in January 2023 at the community level. Contraceptive, antenatal and postnatal care services for mothers and newborns have been deployed at two levels: community and institutional (health centres and zone hospital).

Community Component

The activities were initiated in the districts of Lokogba and Adjahonmé, then gradually extended to Klouékanmè, Tohou, Djotto and other localities. The strategy began with a qualitative review in each village

through focus groups bringing together women and men aged 20 to 80. These pre-targeted groups included key actors such as women's groups, local elected officials, village councillors, religious or traditional leaders, as well as some traditional healers and birth attendants. All the participants were from the villages concerned.

Afterwards, the MSF team met with the village chiefs of each district, the Health Centre Management Committees (COGES)[8] and the health centre majors to re-present the organisation's role and strategy, and to solicit their support. Their collaboration made it possible to identify three women leaders per village, based on precise criteria: knowing how to read and write, accepting volunteering, and being available. These women leaders, also known as volunteer members of the community (MVCs),[9] underwent a five-day training on MNH/SRH, communication techniques and the use of data collection tools.

Officially presented in their villages, they support three target groups of women: those of childbearing age, pregnant women and mothers of newborns. They conduct awareness sessions on MNH/SRH, conduct home visits, one-on-one consultations and group talks, and refer women to health centres when necessary. These activities contribute to the early detection of women at risk and the reduction of obstetric complications.

To support their work, MSF provided them with tools (image boxes, flashlights, etc.) and provided monthly supervision to coach them on communication techniques, check the quality of the data collected and find shared solutions to the difficulties encountered. Every three months, a refresher course is organised to strengthen their knowledge and skills. The data collection sheets are collected each month and integrated into a database to measure the impact of the activities. Each woman leader also receives a monthly bonus of 10,000 CFA francs to cover her communication and transport costs.

Health Structures Component

At the level of the health centres, MSF's logistics team carried out a needs assessment, followed by rehabilitation work and the provision of equipment and materials. Tricycles have been provided to facilitate referrals for women between villages and health centres.

Health centre staff have been trained on quality hygiene care and standard protocols. Each supported centre has recruited a maintenance worker, trained by the IPC team. In addition, a midwife was assigned to each supported maternity and trained for four days on essential BEmOnC and SRH practices, followed by regular coaching sessions led by MSF midwives. The two staff mobilized (midwife and maintenance worker) are recruited locally by the health centres, but their salaries are financed by MSF, which constitutes direct support for the human resources essential for the quality of care. At the Klouékanmè zone hospital, a referral structure for CEmONC, MSF directly provides urgent and life-saving care for patients without financial resources, thus guaranteeing access to life-saving interventions regardless of their ability to pay. Although the maternity ward did not receive direct support, the quality of care in the operating room was improved through refurbishment work, including the installation of a sterilization department, a laundry room and the implementation of proper patient flow in accordance with standards. The hospital is now better organized to provide CEmONC and reduce the risk of complications. A maintenance worker, two midwives and a nurse were recruited to support the service, while an MSF gynaecologist provided technical follow-up and training in MNH/SRH. IPC officials also strengthened the capacity of all hospital staff on hygiene.

[8] The COGES are made up of members of the community, elected at a general assembly. They typically include health centre managers, community leaders, some health service workers, and community-based civil society representatives.

[9] These women, from the communities and initially designated as Volunteer Members of the Community (MVC), were renamed "women leaders" in consultation with the Beninese government, in order to avoid confusion with the community-based volunteer staff of the Ministry of Health.

Free care

Targeted free care is another pillar of the project. In health centres, it specifically covers the first and fourth antenatal consultations (ANC1 and ANC4), as well as certain services for particularly vulnerable women (widows, disabled women, mothers without sufficient resources). Eligibility is made on presentation of the ARCH card or, failing that, after a survey conducted jointly by a woman leader and the village chief. At the zone hospital, free treatment applies to CEmONC cases for which the family cannot pay the bill, and the assessment of the situation is then carried out directly by the health personnel. Women benefiting from this free delivery also receive, during childbirth, a hygiene kit including mosquito net, soap, bowl, cup, water disinfection tablets and 25-liter canister. Finally, an emergency box has been placed in each maternity to facilitate access to BEmONC in the event of a shortage of stock or the inability to pay immediately. Each month MSF pays the health zone's accounting department to cover the salaries of the staff recruited. In addition, in partnership with local authorities, MSF has strengthened the strategy allowing health teams to travel regularly to remote villages to provide MNH/SRH services.

Safe Abortion Care (SAC)

Safe abortion care, a sensitive issue in the local context, was only set up in June 2024 after nearly two years of preparatory work aimed at establishing a relationship of trust with the communities and getting the practice accepted by midwifery staff. This initial phase focused on uncontroversial themes (antenatal and postnatal consultations, safe delivery, contraception).

Prior to their introduction, a contextual analysis and exploratory discussions (Exploration of Values and Attitudes (EVA) sessions) identified the beliefs, expectations and resistance of communities. A network of 30 "whisperers" – women leaders, facilitators of the Youth-Friendly Centres, community health workers, members of the *Maison des Adolescents et des Jeunes*, and religious leaders – was mobilised to discreetly refer patients to care facilities. These “whisperers” were trained on SAC, confidentiality, the fight against stigma and interpersonal communication.

At the level of health structures, healthcare staff were involved in EVA sessions to identify their perceptions and possible obstacles. The midwives were trained on SAC (drug and surgical) protocols, post-abortion management and the management of complications. Written procedures have been put in place, integrating the SAC into the regular care offer and guaranteeing confidentiality and respect.

Faced with the refusal of some midwives to offer these services, MSF has established partnerships with local private clinics. After the withdrawal of an initial partner clinic, two new collaborations have been set up. At the same time, the National College of Gynaecologists and Obstetricians of Benin (CNGOB), contracted by MSF for this purpose, supported the promotion of the abortion law, the specialized training of providers and the clarification of conscientious objections through a workshop bringing together midwives from the project and the health zone.

Support cycle

MSF's support is based on a two-year cycle per health centre: two new health centres are integrated every two years, while support is gradually withdrawn after two years of support. Currently, five centres are supported: two in the withdrawal phase, two in continuous support and one newly integrated. A sixth centre is due to join the programme in 2025. MSF has already withdrawn from two centres after meeting its capacity-building targets. These centres mainly offer BEmONC, while the zone hospital remains the only structure with almost complete CEmONC functions. Support for the hospital is planned until 2027, when the project closes.

SUMMARY OF METHODOLOGY AND DATA COLLECTION

The mid-term review of the Couffo project, conducted by Global Health Direct for MSF's Stockholm Evaluation Unit (SEU), had three main objectives:

1. **Assess the achievements of the programme from its conception in 2022 to date,** by examining the interventions, activities and implementation modalities of the project.
2. **Identify key lessons learned and propose possible adaptations to feed strategic reflections during the 2025 Annual Operations Reviews (ARO),** and guide decisions on how to consolidate and extend the project's achievements until 2027, the expected end date of the Couffo project.
3. **Create a space for reflection and self-evaluation for MSF staff and partners involved**, in order to strengthen collective learning, highlight the added value of the project, and guide decisions on amplifying its impact over the next two years.

The review was framed by key review questions (KRQ) defining the specific research focus:

1. What is the general approach and what activities have been implemented in Couffo? What was planned and what is actually being done?
2. What changes have been observed following the implementation of the project? How has the project contributed to these changes?
3. How can the achievements of the MSF project be preserved and sustained once the project is transferred to the Beninese authorities?
4. In what ways and for whom was the project a success? Has it been a success for MSF, the Ministry of Health (MOH), the communities and the patients?
5. Is the project design relevant and appropriate to the general/specific objective of the project?
6. What opportunities can be identified to make the project more effective? What challenges remain to be solved?
7. What lessons can be learned from the project's community engagement approach that are relevant to other OCB projects?
8. What lessons can be learned from the collaboration with the Ministry of Health that are relevant for other OCB projects?

GENERAL APPROACH

The review adopts a rigorous, participatory and context-sensitive methodology, focusing on the use of results by stakeholders. It combines mixed methods (quantitative/qualitative) with mechanisms for the active involvement of MSF teams, communities and institutions. With a summative aim, it has been evaluating results since 2022 to identify operational lessons and guide the strategy until 2027, while nurturing a culture of learning. The theory of change (ToC) serves as the guiding thread of the analysis and was refined as the data was collected.

DATA COLLECTION

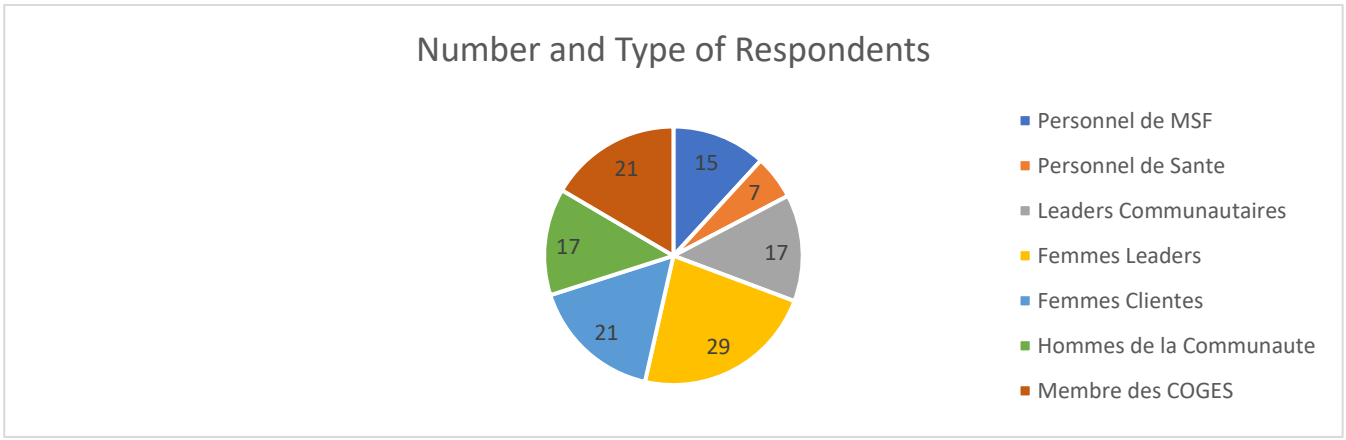
Data collection was based on a combination of documentary, statistical and qualitative sources. A systematic literature review of project reports (2022–2025), logical frameworks, DHIS2 aggregated data for MSF-supported centres and MSF internal monitoring data, and national and international strategic documents identified achievements, gaps and trends based on available indicators.

On the qualitative level, semi-structured interviews were conducted with MSF teams (in Cotonou and Couffo), health authorities, health staff, civil society actors, the partner private clinic, as well as, opportunistically, some patients. Focus groups were held with female patients in the 18-50 age group, mothers of at least two children, housewives, and retailers or farmers, as well as with some vulnerable women such as widows, women who do not have the financial resources to support themselves and who have several dependent children, or women with disabilities, men in their entourage, community leaders (District Chief, Village Chief, Neighbourhood Chief), women leaders, as well as the COGES in four zones representing the different stages of the project. Finally, site visits to health centres, the zone hospital and partner clinic, and communities allowed for observation of practices and anchoring the analysis in local realities. Four sites were selected for the visits, corresponding to the different phases of MSF's engagement during its two-year support period:

- in Djotto, where MSF has just started its activities.
- in Klouékamè, where the organization has been working for more than a year.
- in Tohou, where an exit strategy is underway.
- in Lokogba, where MSF has already disengaged.

This choice makes it possible to illustrate the different stages of MSF's support and to offer an overview of the processes and results related to the duration of the intervention.

In total, the review collected the impressions of 127 individuals, distributed as follows:



ETHICAL CONSIDERATIONS AND INCLUSION

The mid-term review was conducted in accordance with the principles of Gender Equality and Social Inclusion, which permeated the entire methodological process. This resulted in the mobilization of a balanced and diverse team, with an awareness of gender, social and cultural diversity issues. Data collection tools and methods were adapted to local realities (languages, literacy levels, social practices, physical accessibility) to ensure the equitable participation of different profiles, including women, ethnic minorities, populations living in remote areas and marginalized patients.

Rigorous ethical mechanisms have governed the collection of data. Informed consent was systematically obtained, either orally or in writing. Minors under the age of 18 were not included. Particular attention was paid to sensitive topics, such as sexual violence or traumatic experiences, with a strict "do no harm" principle and safe and confidential conditions for free expression of participants.

Finally, data safeguarding and protection mechanisms were put in place at each stage of the mid-term review: anonymous reporting mechanisms, management of risks related to stigmatization or disclosure, secure storage in compliance with GDPR, and deletion of data at the end of the mission. In the event of an emotional or

psychological trigger, a safety net was activated to refer participants to locally available psychosocial or medical support services. Global Health Direct is committed to upholding MSF's values and the ethical guidelines of the SEU, ensuring exemplary professional conduct that respects dignity and human rights.

DATA ANALYSIS

The review is based on a contribution analysis[10], and employs a ToC developed in collaboration with MSF teams. This ToC models the linkages between activities, intermediate results, and intended outcomes, taking into account contextual factors and potential pathways for change. It served as a structuring framework to formulate attribution questions, guide data collection, and support the interpretation of results. The contribution story was constructed from secondary data (literature review, internal reports, indicator table, DHIS2 aggregate data of supported HCs) and primary data (interviews, focus groups, change narratives), with particular attention to triangulation of sources and assessment of the strength of the evidence, categorized into strong, medium, or anecdotal levels.

In addition, the Most Significant Change (MSC) method was integrated into interviews and focus groups to collect qualitative narratives on the transformations perceived by communities, users and health professionals. These stories illustrated the effects felt by the project, supplemented the contribution analysis and enriched the validation workshops, while encouraging collective learning around the most significant changes.

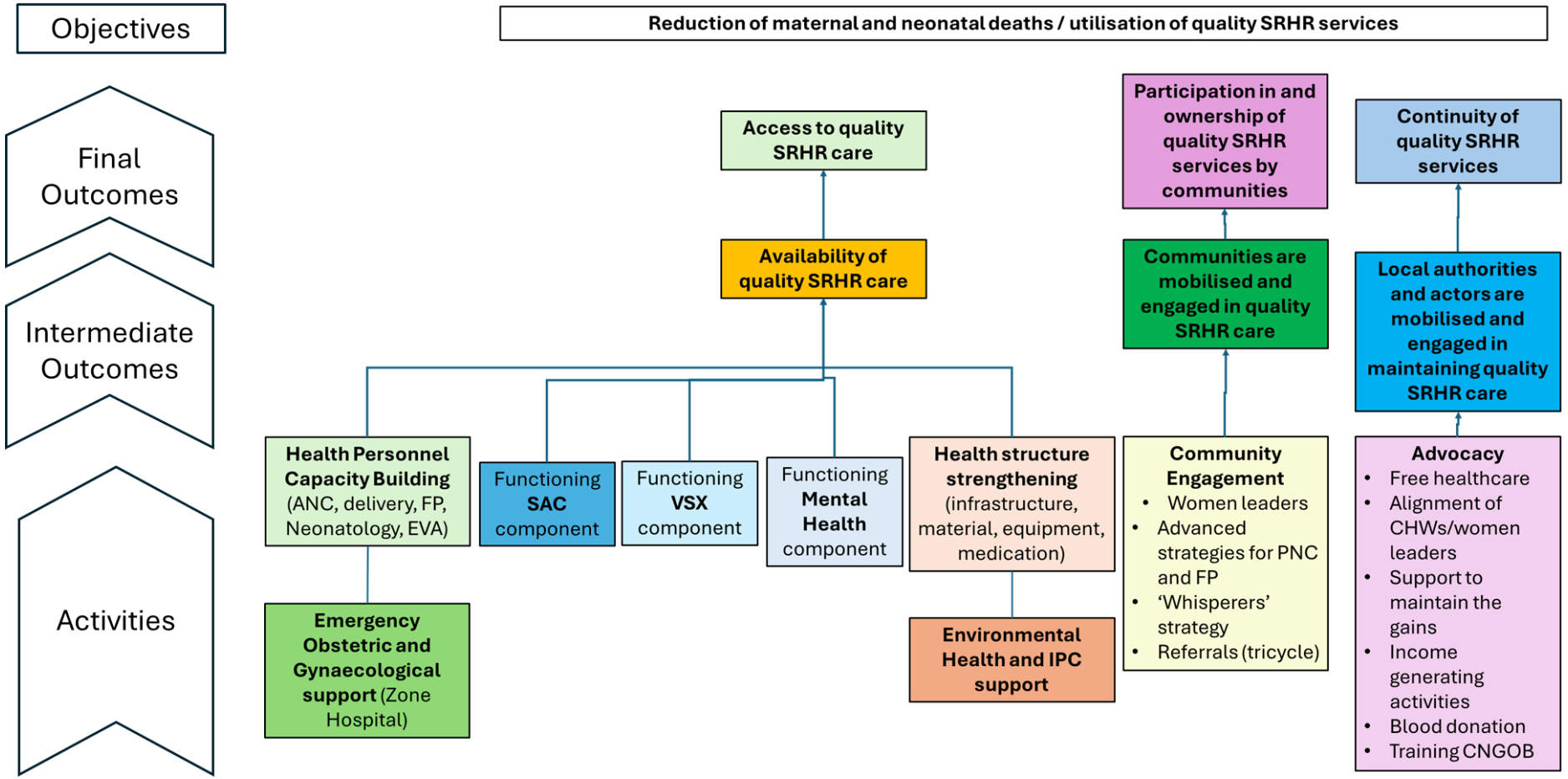
PRESENTATION OF THE COUFFO PROJECT'S THEORY OF CHANGE

INTERVENTION LOGIC: RESULTS CHAIN AND CAUSAL LINKS

Diagram 1 represents the ToC as designed by the review team with the MSF teams. More details are available in Appendix 1.

[10] According to John Mayne's six-step framework

Diagram 1: Couffo Project Theory of Change



Inputs The inputs mobilised by MSF to initiate the project include:	**Human resources** MSF staff (international mobile staff and locally hired staff, local health staff, women leaders.	**Material Resources** Medicines, medical equipment, tricycles for emergency transport, Information, Education and Communication (IEC) supports.	**Technical and financial support** Training, supervision, additional salaries, harmonized care protocols

KEY ASSUMPTIONS

The intervention logic and the pathways of change are based on several assumptions at each level of the results chain:

Table 1: Summary of Key Assumptions

Level of causality	Assumptions
Inputs → Activities	H1.1.: MSF obtains stable and sustainable operational access to the KTL zone, with the approval of the government. H1.2.: Human resources are available and stable with a low turnover. H1.3.: The necessary infrastructure to provide quality care is available and reliable (medicines, equipment, WASH/IPC room) H1.4.: The legal/policy framework is applied to allow targeted free care, SAC services and VSX care H1.5.: Different key stakeholders (COGES, community health workers, women leaders, caregivers) participate in training, coaching, and community activities.
Activities→ Intermediate Outcomes	H2.1.: Staff apply the training received, communities accept interventions H2.2.: Community engagement (women leaders, "whisperers") is accepted, protects confidentiality and generates referrals. H2.3.: The referral/counter-referral mechanisms (tricycles, zone hospital) operate without financial barriers. H2.4.: Monitoring and evaluation systems are in place to monitor quality, referrals and sensitive data. H2.5.: MSF-trained midwives agree to provide SAC H2.6.: Infrastructure/WASH/IPC investments are used, maintained and managed locally. H2.7.: Improving the quality of care generates increased trust, more frequent use of services, and better community adherence. H2.8.: Plans for community management and sustainable financing are established with health centres (HCs), COGES, and communities. H2.9.: The DDS replaces and pays staff trained and deployed by MSF, and salaries are systematically taken over by the authorities after MSF's withdrawal.
Intermediate Outcomes → Overall Outcomes	H3.1.: The increase in the use of services and the continuity of care are reflected in a real decrease in maternal and neonatal mortality. H3.2.: The quality of the medical offer and social acceptability translate into increased use (ANC1–4, assisted deliveries, PCN, FP, SAC, VSX). H3.3.: Confidentiality and perceived security remove the barriers for SAC/VSX. H3.4.: Local structures have sufficient technical, human and financial capacities to maintain the gains.

Overall Outcomes → Objective	H4.1: Increasing access and quality is converted into improved outcomes (morbidity/mortality, violence treated). H4.2.: Social norms are changing over the long term (FP, SAC, VSX) and reduce non-take-up. H4.3.: Quality data informs continuous adjustment and advocacy

LIMITATIONS OF THE REVIEW

Several important limitations must be recognized in order to frame the interpretation of the results. These limitations relate both to the quality and availability of quantitative data, and to the methodological, logistical and contextual constraints faced by the mid-term review.

LIMITATIONS OF QUANTITATIVE DATA

Quantitative secondary data exclusively used: The quantitative analysis is based entirely on aggregated secondary data produced by the MSF project and collected through DHIS2. Some data were only available in aggregate or incomplete format, which limited the depth of possible analyses, especially longitudinal analyses. In particular, disaggregation by health area, sex, age or level of vulnerability was rarely complete or reliable. No independent quantitative primary data collection was conducted, thus limiting the scope for in-depth quantitative analysis and independent external verification.

Inconsistencies in the definitions and scope of indicators: Between 2022 and 2025, several key indicators changed their scope, calculation method or operational definition. For example, some data on antenatal consultations (ANC1/ANC4), delivers, or tricycle referrals, were entered or reported differently depending on the period, the centre, or the tools used. This heterogeneity makes any robust longitudinal analysis complex, especially for comparison between years.

High risk of data entry errors: In some cases, the data used was manually extracted from non-standardized PDF or Word reports, increasing the risk of human error in typing, reading, or interpreting. Many cells were empty, incomplete or contradictory, especially for the years 2022 and early 2023. This is particularly noticeable for VSX and SAC indicators, which could not be reliably quantitatively analysed due to insufficient data volume and low reliability.

Mitigation measures: The team systematically triangulated quantitative data, qualitative data, and field observations to validate or nuance the numerical trends. Each indicator has been recontextualized according to its methodological evolution (change of scope, definition or calculation). To limit the impact of input or extraction errors, cross-checks were performed on the source files, and the analysis favoured general trends rather than precise comparisons. All quantitative results are presented with caution, accompanied by comments on their sources and reliability, especially for indicators where the quality of the data was particularly low.

CONSTRAINTS ON ACCESS TO DATA AND ACTORS

Time and logistical constraints: The timeline of the review was very tight, limiting the time available for in-depth analysis of the data. In addition, site visits coincided with the rainy season, limiting physical access to some remote communities and reducing the participation of certain groups (especially women during

agricultural activities). This has limited the number of focus groups and community interviews conducted, especially in the most remote areas.

Staff turnover and institutional memory: The high turnover of MSF staff and local authorities during the evaluation period meant that some key informants had only partial or indirect knowledge of the history of the project, which may have introduced perception or interpretation biases. Although efforts have been made to trace former job holders, this limitation has impacted the complete reconstruction of the project's trajectory in some areas.

Mitigation: Systematic triangulation of data strengthened the analysis of the review. Targeted requests were also made to field teams to fill in some missing data, and incomplete data disaggregation was clearly flagged in the analysis. Regarding logistical and temporal constraints, the team adapted the methodology by favouring contrasting samples of sites, and reinforced the diversity of the profiles consulted. Efforts were made to reconstruct the history of the project through literature review, cross-interviews, and the use of former officers and supervisors, where possible.

LIMITATIONS OF THE SCOPE OF ANALYSIS

Partial geographical scope: Although the health centres selected for the analysis cover the four phases of MSF's engagement (start-up, ongoing support, ongoing withdrawal and post-intervention), the sample remains limited to five structures (four CS and the zone hospital), which does not allow for generalisation to the entire Couffo department. In particular, centres not supported by MSF or in other health zones were not included, limiting the possibility of comparison with control areas.

Under-documented components: Some components of the project, although important, were little or not at all covered by the review. This is particularly the case for psychosocial support, which was being started at the time of the review, for which very few activities had yet been implemented.

Lack of direct impact measures: Due to the nature of the (non-experimental) review, no rigorous counterfactual-type methods (randomisation, control group) could be used to measure the net effect of the project. The Contribution Analysis has made it possible to reconstruct a plausible chain of effects, but does not allow the results observed to be formally attributed to the MSF intervention exclusively. In addition, the lack of mortality data (indicators that are too infrequent or not disaggregated) limited the possibilities of quantitative validation of the final results.

The limitations identified do not call into question the analytical value of the review, but should be considered for a rigorous and nuanced interpretation of the results.

RESULTS OF THE MID-TERM REVIEW

RELEVANCE OF THE PROJECT DESIGN AND ALIGNMENT WITH NEEDS

KEY RESULTS

2.1.1 Alignment with MNS Priorities

The project's priorities are aligned with the legal and policy framework of the Couffo region, in particular the Operational Plan for the Reduction of Maternal and Neonatal Mortality 2018-2022 (H1.4. validated).

2.1.2 Inclusion of a Community Engagement Model

The inclusion of strategic community mobilization, combined with an approach of material, financial, and human resource support to health centres, allowed for the participation of different key stakeholders in the development and implementation of the project, highlighting the relevance of the project approach. (H1.5. validated)

Community engagement through women leaders and "whisperers" has been accepted by community members as it creates bonds of trust, confidential communication channels, and leads to more referrals to MNH services (H2.1. validated).

According to community leaders, women leaders, and service users themselves, the project design appears relevant and appropriate to the project's objectives (KRQ5).

GOOD ALIGNMENT WITH MATERNAL AND NEWBORN HEALTH (MNH) AND SEXUAL AND REPRODUCTIVE HEALTH (SRH) PRIORITIES IN COUFFO

Faced with an alarming health context in Couffo, the project is relevant and strategically in line with local public health priorities, in particular with the Operational Plan for the Reduction of Maternal and Neonatal Mortality (PO-RMMN) 2018-2022 of the Ministry of Health, which is based on interventions of several kinds:

- Clinical: Improving MNH care.
- Managerial: Optimization of the management of health services.
- Policy and Legislation: Development of policies and legislation that support maternal and child health.[11]

The Couffo project adopts a mixed and holistic approach that combines the provision of services in health facilities with prevention and community mobilization actions. This dual dynamic makes it possible to address the main issues of MNH and SRH in the department in an integrated manner, by acting both on improving the quality of care and on reducing access barriers, particularly for women and adolescent girls.

In concrete terms, the project addresses several major challenges. On the one hand, it improves the availability and quality of MNH and SRH care by strengthening the skills of staff, optimising the management of services and ensuring that certain essential care is provided free of charge. On the other hand, it addresses the socio-cultural factors that hinder the use of services, particularly in the areas of family planning, adolescent health, and care for survivors of sexual violence (VSX).

[11] Operational Plan for the Reduction of Maternal and Neonatal Mortality in Benin PO-RMMN 2018 – 2022, Directorate of Maternal and Child Health – Ministry of Health (March 2018)

The project also acts on the structural barriers that limit access to care. Faced with transport difficulties and delays in care, it has introduced tricycles for community referrals and strengthened the transfer system between Couffo and Mono, particularly for complex neonatal emergencies. Finally, it reduces the financial burden on households by ensuring that certain MNH and SRH services are free of charge.

Thus, this integrated approach is a central lever in the causal pathway of the project's ToC: by providing quality services that are accessible and accepted by communities, the project promotes sustainable improvements in access to and use of MNH and SRH care.

LESSONS LEARNED

1. Tailor approaches to the specific maternal and child health needs of the local context

The experience of the Couffo project shows that the relevance and impact of an intervention depend on its ability to simultaneously respond to several levers of demand expressed by communities. This includes ensuring access to emergency obstetric care, ensuring the availability of family planning services, building community awareness, and integrating cross-cutting services like mental health.

In this context, the improvement of MNH care must be prioritized, with a particular emphasis on the quality of services and the establishment of appropriate mechanisms to stimulate the demand for quality MNH and SRH care in communities. The Couffo project exemplifies this approach through its community engagement component, which has not only increased the use of services, but also strengthened trust between communities and the health system.

2. Promote a holistic and integrated intervention model

An integrated approach combining quality clinical care (BEmONC/CEmONC), facilitated access to primary health care (SAC/VSX), structured community engagement (women leaders, whisperer groups) and the integration of complementary services, particularly in mental health, makes it possible to target a range of challenges, such as improving quality MNH and SRH care, socio-cultural barriers related to family planning and SAC and VSX, and barriers to access to care due to transport difficulties (addressed by the Couffo project through the implementation of tricycles and a strengthening of the referral system between the Couffo and Mono departments for complicated neonatal emergencies) and costs related to these services (addressed by the project through free care for certain services of MNH and SRH)

INCLUSION OF A RELEVANT AND EFFECTIVE COMMUNITY ENGAGEMENT MODEL

A well-adapted, relevant and effective model of community engagement

Community engagement is one of the strongest pillars of the Couffo project, unanimously recognized by respondents[12] as a key component that has enabled effective community mobilization around the issues of MNH, SRH including FP, as well as SAC and VSX services.

The approach was designed as a strategic extension of the clinical component. As one MSF staff member points out:

[12] Interviews with local authorities, MSF staff, health staff, and focus groups with women leaders, women patients and men in the community

> *"We identified three major gaps: obstetric care, sexual and reproductive health (including safe abortion services), and non-use of care. Hence the choice of a two-anchored approach, clinical and community-based."*[13]

This coupling between strengthening the provision of care and mobilizing communities has proven to be particularly relevant in stimulating demand, improving access to services and strengthening positive perceptions of health.

A participatory and legitimate model

The system is based on a participatory and contextualized approach, particularly in the process of selecting women leaders, chosen directly by the communities[14]. This method has strengthened their local legitimacy and facilitated their social acceptance, including on sensitive issues such as SAC and VSX:

> *"At first, there was refusal and rejection of SAC and VSX themes, but gradually the community accepted our messages."*[15]

The role of women leaders is central. They lead educational talks on SRH, conduct home visits for antenatal follow-up (ANC) and postnatal follow-up (PCoN), raise awareness about family planning and nutrition, and help recognize danger signs during pregnancy. They distribute referral vouchers, remind women of medical appointments and encourage assisted deliveries. Their proximity, social legitimacy and ability to address intimate subjects such as contraception or SAC were perceived by service users as a decisive factor of trust:

> *"Women leaders follow up on referrals, and caregivers also ask this question after treatment."*[16]

Patients confirm:

> *"The activities of women leaders have played a key role in this change [in the use of health services], helping to change behaviour in a sustainable way. Communities are now recognizing the importance of using health centres for care, including maternal and newborn health."*[17]

> *" Community engagement has made our job much easier, because women leaders and community health workers support us in raising awareness. Thanks to this, communities are more willing to come to health centres."*[18]

> *"It is community engagement that has made the project's activities work: women leaders and community volunteers inform us, reassure us and encourage us to go to the health centre."* [19]

Changes in perceptions

This action has also helped to transform male perceptions. The majority of men now recognize the benefits of family planning and support their wives' participation in activities:

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[13] Interviews with MSF staff

[14] For the selection of women leaders, MSF defines basic criteria, including being able to read and having a certain influence within the community. Responsibility for the selection is then handed over to community leaders, who organize it in consultation with community members.

[15] Interviews with women leaders

[16] Interviews with female patients

[17] Interviews with community leaders

[18] Interviews with health personnel

[19] Focus Group with Women Leaders

> *"Generally these themes are not accepted, but with awareness sessions family planning is more and more accepted. SAC and VSX may not be as easily accepted, but will come with time."*[20]

Similarly, awareness-raising has made it possible to reduce resistance:

> *"It was difficult at the beginning with family planning, people said it made you sterile. Now, thanks to awareness-raising, women come more easily for the ANCs and even talk about cases of sexual violence."*[21]

"Whisperer" groups have played a key complementary role in creating a confidential space to discuss sensitive topics such as SAC and VSX, and discreetly refer patients to care facilities.

Persistent limitations and challenges

Despite these successes, several challenges weaken the sustainability of the model. The main one lies in the disparity of status between women leaders, who are hired on a voluntary basis, and community health workers (community health workers) who are paid by the State. This difference can fuel a sense of injustice and affect motivation, sometimes leading to gradual demobilization. However, it is important to remember that at the time of their identification, the women leaders had been made aware of and had accepted this volunteer commitment, designed as a civic contribution to the health and well-being of their peers. The community health workers, for their part, have a much broader and more complex set of responsibilities, based on a "One Health" approach, which justifies the difference in status between the two profiles. However, a reinforced communication effort is still necessary to clarify these roles and avoid any confusion or perception of inequality, while promoting the complementarity of these two actors in the community ecosystem. Some women leaders also mention workload fatigue, persistent cultural resistance or social stigma:

> *"Stigmatization on contraceptive issues. This situation sometimes demotivates us."*[22]
> *"We are sometimes sent away from homes when we talk about contraception."* [23]

At the same time, some pregnant women refuse referrals for fear of a caesarean section, or do not perform intermediate ANCs (2nd and 3rd), which are considered too expensive, which generates tensions with the women leaders who promote these services. Some actors, such as COGES, also regret not having been fully involved in the process of selecting women leaders. Finally, in the areas where MSF has withdrawn, the continuity of community engagement remains fragile, due to the lack of solid institutional mechanisms to take on their activities.

Alignment with local priorities

The overall design of the Couffo project is seen as aligned with the priorities expressed by local communities and stakeholders:

> *"MSF carried out an in-depth analysis of the health situation in Benin, which identified malaria and maternal, newborn and child health as priorities. These areas were also aligned with the national priorities set by the government. (…) The priorities initially identified by MSF have proven to be relevant and remain fully justified to this day."*[24]

[20] Interviews with women leaders
[21] Interviews with women leaders
[22] Interviews with women leaders
[23] Interviews with women leaders
[24] Interviews with MSF staff

The actions implemented — targeted free care, community engagement, improvement of clinical quality — have contributed to reducing financial, social and structural barriers, in particular for antenatal consultations, family planning and the management of obstetric emergencies.

In short, community engagement, as implemented in the Couffo project, is an essential link in its intervention logic. By entrusting communities with the selection of their own women leaders, MSF has established a participatory and culturally rooted model. It has promoted access to services (ANC, PNC, assisted deliveries, family planning, SAC, and VSX care), transformed community perceptions, including among men, and strengthened trust in the health system. However, the challenges of motivation, recognition and sustainability after MSF's withdrawal are critical assumptions for the sustainability of this model.

LESSONS LEARNED

1. Design an integrated community engagement strategy, anchored in real needs

By anchoring the project in both clinical and community settings, the project was able to simultaneously address barriers to access (distance, cost, stigma) and barriers to demand (social norms, lack of trust, low awareness). This integrated approach has proven to be particularly relevant in sensitive areas such as family planning, pregnancy monitoring, and neonatal health.

2. Sustainably strengthen adherence to care through local engagement

The active mobilization of women leaders and "whisperer" groups has led to a gradual but profound transformation of behaviour within communities. These local actors have played an essential role as trusted relays, facilitators of dialogue, and agents of social change. Their involvement has promoted local ownership of health messages, strengthened the credibility of the healthcare system, and supported adherence to services even in the most sensitive areas such as SAC and VSX.

IMPLEMENTATION OF ACTIVITIES AND ADAPTATION

KEY RESULTS

2.2.1. Infrastructure and equipment support

Support to overcome structural weaknesses in health centres (water tower, rehabilitation and upgrading, provision of new essential equipment) has made it possible to make available the equipment and space necessary to provide quality services and care (H1.3. validated).

Infrastructure/WASH/IPC investments are used but concerns were shared by service providers and COGES regarding their long-term maintenance as sustainability and handover plans after MSF's withdrawal do not exist systematically in the HCs (H2.6, H2.8, H3.4 not validated, KRQ6).

2.2.2. Support for capacity building for 12 midwives

By strengthening the technical skills (BEmONC, FP, SAC, IPC, etc.) of 12 midwives in the supported HCs to update and adapt their skills to the context, MSF has acted on an essential lever to improve the care of patients and guarantee compliance with quality standards. However, the data from the review show an insufficient inclusion of various participants, leading to an internal imbalance, an overload of work for those trained, a demotivation for the others, and a risk of dilution of standards (H2.1. partially validated).

The staff trained by MSF do not seem to be systematically taken back by the health authorities and there is no plan to sustain the gains that would allow the new capacity-building system to be viable in the long term after MSF's gradual withdrawal (H2.9 and H3.4. not validated, KRQ6).

2.2.3. Financial and institutional support

Free care, thanks to the financial and institutional support of MSF, removes a major financial barrier for potential users of services, which seems to have improved the rate of attendance at the HCs (H2.7. validated). However, this free care is not institutionalized and the ARCH system does not allow for an equitable application of free care once MSF has withdrawn (H3.4. not validated).

Institutional support for staff in the HCs was also appreciated, but structural or organisational elements seem to limit the ability of the HCs to respond in parallel with MSF's sliding scale salary model (H3.4. not validated)

2.2.4. Advocacy support

Despite the provision of technical support that reduces the challenges of supply and provision of quality SRH and MNH services, MSF's support seems to be mainly useful in the short term but more fragile in the long term without a concrete exit strategy to maintain these gains in the HCs (QCR6). A formal and structured advocacy strategy does not exist, but the review highlights several structural challenges that would benefit from strategic advocacy.

INFRASTRUCTURE AND EQUIPMENT SUPPORT

What infrastructure support has been provided?

Strength of the evidence – Strong ☑

From the outset of the project, MSF identified significant structural weaknesses in the health centres, including the lack of access to safe drinking water, a critical element in ensuring the quality of care, particularly in MNH. To address this, the organization has installed water towers in all supported health centres (Photo 1), ensuring continuous access to water. It has also rehabilitated and upgraded maternity wards, including renovation, cleaning, wall repair, sanitation, disinfection and painting. These improvements have been complemented by the implementation of WATSAN (incineration pits) and infection prevention and control (IPC) measures.

Photo 1: Water tower in Tohou

What changes have taken place as a result of this support?

The service providers and coordinators welcome the visible progress in just two years of support:

- *"The monthly income of the center, which used to be about 400,000 CFA francs, now exceeds one million CFA francs. […] Significant improvements have been made to the infrastructure: the centre now has access to clean water — instead of having to travel to the river — and an incineration well, which has strengthened WATSAN and infection prevention and control (IPC) practices."*[25]
- *"The refurbishment of the environment and the availability of equipment have led to an increase in ANCs and a decrease in home births."*[26]

This dynamic has had a tangible effect not only on the quality of care, but also on the attendance of the centres and the motivation of the staff. From the point of view of the Ministry of Health, the increase in revenues can be seen as progress in terms of the financial sustainability of the structures. However, on the MSF side, the emphasis is above all on improving the use and quality of services, in the humanitarian logic that defends free care to remove financial barriers and guarantee equitable access, rather than on generating income for the structures.

What equipment support has been provided?

MSF has strengthened the capacity of the centres and the hospital by providing essential equipment. Three health centres (Klouékanmè, Toviklin and Lalo) have been equipped with additional ultrasound machines, strengthening diagnostics at the primary level. The area hospital has also been equipped with an ultrasound machine, a testing device for the quality of blood for donation, as well as a basic neonatology unit to improve the care of newborns. MSF has also occasionally supplied the centres with its own stocks of medicines, ensuring continuity of care. Finally, tricycles have been made available to facilitate the referral of patients to the centres or the local hospital.

What changes have taken place as a result of this support?

These investments have generated improvements that are directly perceived by users:

> *"The free care for certain consultations and the better quality of the reception encouraged us to come to the health centre more often."*[27]
>
> *"The significant change is the availability of EmONC services and the decrease in home births thanks to rehabilitation and equipment."*[28]

The awareness-raising work of women leaders has also amplified the impact of these investments by informing the population about the availability of services, which has contributed to increased demand and better use of the structures.

Sustainability concerns

Despite this recognition, concerns persist about the maintenance of these facilities and infrastructure after MSF's planned withdrawal after two years. Community stakeholders — COGES, women leaders, community leaders and users — particularly highlight the risk associated with the maintenance of infrastructure and equipment in a context where the capacity of the public system remains limited:

[25] Interviews with health personnel

[26] Interviews with health personnel

[27] Interviews with female patients

[28] Interviews with health personnel

"The community and the health centre officials are wondering how activities will be maintained if MSF withdraws, especially in terms of maintaining equipment and motivating staff."[29]

"We appreciate the free and good services, but we don't know if this will continue after MSF leaves. If the equipment is not maintained and the midwives leave, we risk going back to the same difficulties as before."[30]

Infrastructure and equipment support is a central pillar of the Couffo project's intervention logic, contributing directly to the provision of comprehensive and quality SRH services. However, the availability and maintenance of these gains after the withdrawal of MSF represents a critical assumption of the ToC. In a context of limited financial and technical capacities of the public system, the issue of sustainability remains a major challenge.

LESSONS LEARNED

The rehabilitation and equipment of maternity wards has increased the quality, safety and attractiveness of care.

The rehabilitation of maternity wards, access to drinking water, the installation of essential medical equipment (ultrasound machines, blood testing devices) and the supply of medicines have had an immediate impact on the working conditions of providers, the safety of care and the use of services.

Material support strengthens the confidence of users and the performance of structures.

The absence of institutional mechanism for maintenance and financing threatens the sustainability of the gains: The absence of solid mechanisms on the side of the local health authorities in terms of maintenance and financing is a critical hypothesis to be monitored in the continuation of the project.

SUPPORT FOR CAPACITY BUILDING OF HEALTH PERSONNEL

Strengthening human resources and clinical skills

MSF provided targeted and organisational support to the Klouékanmè zone hospital and seven health centres, building the capacity of health care staff, particularly midwives, through specialised training (C/BEmONC, EVA, family planning, SAC, VSX) and clinical coaching.

The review highlights the positive impact, but also the limitations, of these training activities.
A total of 12 midwives (divided between the HCs and the zone hospital) benefited from targeted sessions on key themes such as infection prevention, emergency obstetric care, SAC and the management of VSX. These monthly trainings, supplemented by bi-monthly coaching, were particularly appreciated by the midwives:

"I have a good perception of the training, it really helped us to strengthen our skills."[31]

"The training we received was effective, appropriate and directly useful in our daily work." [32]

"The training was sufficient and strengthened our ability to better care for patients." [33]

[29] Interviews with the COGES
[30] Interviews with the COGES
[31] Interviews with health personnel
[32] Interviews with health personnel
[33] Interviews with health personnel

Alignment and inclusion challenges

However, some of training content appears to be out of step with national protocols (for example for the cleaning of sanitary tools and equipment), sometimes creating confusion and tensions:

> *"The training was sufficient and reinforced by supervision. But sometimes there are contradictions between Benin's care protocols and those of MSF taken from the WHO. MSF should have involved the national trainers to meet this challenge."* [34]

It should be noted that, in general, MSF's protocols are largely inspired by those of the WHO, with adaptations based on field experiences. In the Beninese context, the difficulty often stems from the fact that national protocols are not regularly updated and are sometimes out of step with international recommendations. MSF is therefore working with the Ministry of Health to strengthen harmonization and promote better coherence of practices.

In addition, some of the non-trained staff (nurses, pharmacists, chief medical officers) feel excluded from the capacity-building system, which fuels an internal imbalance. This situation leads to work overload, demotivation and the risk of dilution of quality standards:

> *"When I started my service in 2023, the care providers who are not supported by the project refused to offer the services according to quality assurance standards because they felt that it was unpaid additional work. There have been several working sessions, consultation with the authorities so that this attitude changes."*[35]

These findings underline the need to harmonise content with national standards and to extend training to all healthcare staff. The involvement of local trainers appears to be a key avenue for improving coherence, promoting ownership and consolidating the sustainability of achievements.

Capacity building for health workers is an essential link in the Couffo project's theory of change. By equipping midwives with up-to-date and adapted technical skills, MSF is acting on a decisive lever to improve quality of care and community confidence. Nevertheless, the effectiveness of this support is conditioned by three critical factors: the stability of human resources (H1.2), the consistency of quality standards to generate long-term trust and adherence (H2.7), and the capacity of the public system to reabsorb salaries and staff after the withdrawal of MSF (H2.9). These dimensions represent critical assumptions for the sustainability of results and require monitoring and an appropriate transition strategy:

- **H1.2 – Available and stable human resources with low turnover**

  MSF's support has made it possible to strengthen the skills of a core group of midwives. However, the partial exclusion of other categories of staff and the lack of guarantees on the stability of human resources weaken this hypothesis. The overload and demotivation observed among some non-trained providers suggest an increased risk of turnover, especially if the acquired skills are not institutionalized.

- **H2.7 – Improved quality of care generates trust, increased use and community adherence**
  The evidence collected shows that the quality of training and coaching has strengthened clinical skills, which has resulted in better care and positive patient perception. This partly confirms the hypothesis: the increase in the quality of care promotes confidence and stimulates demand. Nevertheless, inconsistencies between MSF and national protocols risk weakening this dynamic by generating confusion and loss of credibility with providers and communities.

[34] Interviews with health personnel

[35] Interviews with MSF staff

- **H2.9 – The DDS replaces and pays MSF-trained and deployed staff**

  This hypothesis remains fragile. The review shows that while MSF is funding salaries during its intervention, there is still no clear and systematic mechanism to ensure retention by the DDS after MSF's withdrawal. The concerns expressed by service providers and the observed overload reveal that the sustainable integration of trained staff into the public system is far from guaranteed. This uncertainty is a critical point for the sustainability of the gains.

RECOMMENDATIONS

1. Train all healthcare providers on MNH, VSX-SAC topics

To ensure the constant availability of quality services and ensure compliance with protocols, it would be beneficial for all providers in the health centres supported by the project to be trained in all the themes covered by MSF: MNH, VSX and SAC. This inclusive approach avoids a concentration of skills among a few individuals, which can lead to work overload and risky dependence. By systematically strengthening the capacities of all health workers, MSF will help institutionalise good practices and make services more resilient, even after it has been withdrawn.

2. Harmonize care protocols between MSF and the Ministry of Health

The review highlights not so much a discrepancy between MSF's care protocols and those of the national system, but rather the absence, non-updating or lack of knowledge of certain Ministry of Health protocols by providers. This can create confusion and affect staff motivation. It is therefore recommended to continue and strengthen the process of collaboration between MSF and the MoH to support the updating, dissemination and adoption of the national protocols, directly involving national trainers. This joint work, which has already begun on themes such as neonatology, antibiotic therapy in the operating room and the management of VSX, makes it possible to harmonize practices, ensure the coherence of messages and consolidate the integration of the project into the national health architecture.

3. Set up regular refresher sessions

Beyond initial training, it would be important to organize periodic refresher sessions (beyond coaching) to update providers' knowledge, correct gaps in the application of protocols, and maintain a high level of quality in the delivery of care, including after MSF's departure from supported HCs. These sessions could be based on harmonized protocols and mobilize both MSF and MoH trainers, in a logic of collaboration and transfer of skills. They would strengthen not only the technical competence of health workers, but also their commitment and confidence in the project's shared standards.

LESSONS LEARNED

- Combining training and regular clinical coaching works. The monthly sessions, supplemented by bi-monthly coaching, are well accepted and enhance practical skills.
- Limiting support to a single group creates islands of competence, overload, demotivation and dilution of standards.
- Differences in status/remuneration (volunteers vs. non-supported staff) fuel resistance; provide for equity measures (allowances, recognition, planned workload).

FINANCIAL AND INSTITUTIONAL SUPPORT

Free healthcare and sustainable financing

One of the pillars of the Couffo project was the introduction of targeted free health care, which was perceived by respondents as aligned with local priorities and directly addressing urgent needs for antenatal consultations (ANCs), family planning (FPs) and obstetric emergencies. This targeted free care has removed a major financial barrier for women users, promoting equitable access to MNH and SRH services. It has also contributed to better attendance at facilities and increased revenue for health centres. The review notes that this integrated approach has built community confidence and boosted demand for services.

Structural limitations and systemic fragility

However, the national context remains marked by strong limitations. The ARCH system (Insurance for the Strengthening of Human Capital) provides for various free schemes (specific care, and coverage for the "extreme poor"), but its application remains uneven. Many vulnerable patients continue to be excluded due to a lack of clear means or mechanisms of identification. This fragility reduces the capacity of the public system to sustain the achievements of the MSF project, which applies a broader and more inclusive definition of vulnerability.

Challenges related to staff compensation

The question of the staff salaries is another critical point in the intervention logic. In several centres, the gradual withdrawal of MSF has led to the government not replacing staff or paying salaries. Some posts remained vacant, while existing staff did not receive remuneration as planned. However, the revenue of the centres, although rising sharply (for example in Tohou, from about 400,000 CFA francs to more than one million), remains allegedly insufficient[36] to cover salaries and ensure the continuity of services. This situation weakens the motivation of the staff and threatens the quality of care.

As one official explains:

> *"Regarding the payment of health staff's salaries, MSF covers all salaries during the first year of employment. From the second year onwards, a sliding scale funding model is introduced: MSF provides 80% of salaries in the first quarter, 60% in the second, 40% in the third and 20% in the last quarter. The hospital is then responsible for gradually compensating for the remaining share."*[37]
>
> *"In the memorandum of understanding, the hospital and the HC should pay part of the salaries to cover social security, taxes and the cost of drug reimbursements to vulnerable people. None of these clauses were respected, which meant that the weight remained on the health zone. […] When MSF leaves a HC, the population moves to the newly enlisted HC to benefit from free access."* [38]

In addition, hypothesis H2.8 postulates that community management and sustainable financing plans would be established jointly with the HCs, COGES and the communities. However, the findings of the review show that this hypothesis is weakly verified.

- While target free services and increased revenues have improved financial viability in the short term, no clear joint management mechanism has been established with the COGES to plan the reinjection of

[36] Interviews with health personnel

[37] Interviews with health personnel

[38] Interviews with local authorities

these revenues into the maintenance of gains (maintenance of infrastructure, replacement of equipment, financing of human resources).

- COGES and communities are often consulted, but their effective involvement in financial planning and management remains limited. This reduces their ability to play a leading role in the continuity of the model after MSF's withdrawal.
- The lack of strict contractualization or accountability mechanisms for the use of local revenues undermines sustainability: the centres struggle to mobilize their revenues to cover essential costs (salaries, maintenance), and the responsibility falls on the DDS, which is already underfunded.

In practice, the free access implemented by MSF has created a positive dynamic of confidence and increased attendance (partially validating H2.7), but without the consolidation of sustainable community financing plans, the risk remains that these gains will erode quickly after MSF's withdrawal.

The introduction of targeted free health care has had an immediate and positive impact on access, equity and community trust. However, the limitations of the ARCH system, the lack of clear mechanisms for the retention of salaries by the authorities (cf. H2.9) and the absence of real sustainable management and financing plans involving HCs, COGES and communities (H2.8) weaken the sustainability of the gains. In a context where the institutionalization of free health care at the national level remains unrealistic in the short term, it seems more relevant to direct efforts towards pragmatic and appropriate solutions: strengthening transparency and local consultation, formalizing community management plans, and exploring alternative financing mechanisms to consolidate the project's achievements while maintaining equitable access to care.

RECOMMENDATIONS

Strengthening local management and financing mechanisms for the sustainability of targeted free care
Rather than aiming for an immediate institutionalization of free access at the national level, MSF and the project would benefit from focusing their efforts on strengthening local management and financing mechanisms, in collaboration with the HC, COGES and communities. This pragmatic approach would make it possible to consolidate the gains made in terms of equity of access to care, while gradually preparing the ground for a possible future alignment with national policies.

Administrative and financial capacity building

The DDS, MCZ and health centres must be supported to effectively manage human and financial resources. The use of a specialized consultant can be considered to support this process.

Setting up a post-intervention follow-up system

Regular monitoring of key indicators in sites where MSF has withdrawn must be established in order to detect any regression and act quickly.

Reflection on the optimal duration of MSF's commitment

The current period of two years per site is perceived by the respondents as too limited to fully consolidate the gains, particularly in terms of continuity of services and stabilization of staff before transfer. An in-depth reflection should be carried out with the Ministry of Health and community actors in order to determine the optimal duration of support, taking into account the structural issues that have not yet been resolved. Rather than simply extension, the duration of support should be conditional on clear milestones for institutional strengthening and the establishment of sustainable mechanisms, in order to ensure that sustainability is built on solid foundations.

LESSONS LEARNED

Free healthcare as a lever for access and trust

The introduction of (some) free health care has removed a major financial barrier, increased the use of services (ANC, FP, C/BEmONC), and strengthened community confidence in health structures.

Limitations of the ARCH system and institutional fragility

The uneven application of national free health care schemes (ARCH) still excludes many vulnerable patients. This highlights the need for strong institutional mechanisms to sustain the gains made after MSF's withdrawal.

Fragility related to staff remuneration

The non-replacement of staff and the lack of payment of salaries by the government after the withdrawal of MSF threatens motivation and quality of care. Local revenues, although increasing (e.g. Tohou: 400,000 FCFA → 1 million), are not enough to cover salaries.

Need for a gradual and contextualized transition

Challenges related to human resources, logistics and financing show that a clear and progressive strategy is needed to transfer responsibility for gains to the national system and avoid their rapid erosion.

ADVOCACY SUPPORT

Several key issues require concerted action with national and local health authorities, as well as with community stakeholders. Although several lines of advocacy were observed by the monitoring team, the project team does not seem to have developed a systematic or documented strategy to do so:

A first area of advocacy concerns the recognition and motivation of women leaders, whose volunteer commitment can create tensions in relation to the paid status of community health workers. In a context where the national community health policy places the community health worker at the centre of the system and where the remuneration of the community health workers themselves remains fragile, a direct plea for the institutional remuneration of women leaders seems unrealistic in the short term. It seems more relevant to continue the strategy already initiated by MSF to strengthen the capacities of women's groups, in particular through income-generating activities in partnership with Éleveurs sans Frontières. This approach aims to support the economic empowerment of women leaders, while strengthening their role in communities and the continuity of their health activities:

> *"I appreciate the approach of community engagement, I just suggest that there be a harmonization between the motivation of women leaders and community relays, otherwise women leaders will disappear, whereas in my opinion, this is the foundation of community engagement."*[39]

A second axis concerns the **sustainability of sensitive services (SAC, VSX).** Conscientious objection, widely practiced by midwives, limits the effective supply despite the demand. The review highlights the importance of targeted advocacy to remove these institutional and socio-cultural barriers, clarify the legal framework and encourage social acceptability. Partnerships, such as with the CNGOB, have already been mobilised to strengthen training and support the dissemination of good practices:

[39] Interviews with health personnel

> *"The [women leaders] have raised awareness about SAC services and the issue of sexual and gender-based violence. In general, these services are well perceived in the community and recognized as useful. However, some families remain opposed to the use of SAC, fearing that these services, particularly in connection with the termination of pregnancy, could lead to serious risks or even death. This fear fuels a form of persistent resistance within the community, which further limits their acceptance and use in some households."*[40]

Finally, the monitoring team suggests advocating for **sustainable financing and the institutionalization of achievements**. This includes the integration of interventions (free care, tricycle management, human resources) into the plans and budgets of the Ministry of Health, the harmonization of care protocols with those of the national system, and technical support for transition planning. The catalytic approach suggested by this review, at the crossroads of humanitarian action contributing to the strengthening of the health system, implies positioning oneself as a catalyst for systemic change, by supporting the authorities and disseminating local good practices:

> *"In addition, the free care offered by MSF has led to better care for women and has led to a significant increase in the use of health services. However, community members are expressing concern about MSF's departure. Although they were informed from the beginning that this was a temporary project, the implementation of the withdrawal is perceived as sudden. They believe that they are not sufficiently prepared to ensure the sustainability of the gains."*[41]

[40] Interviews with female patients

[41] Interviews with the COGES

RECOMMENDATIONS

Institutionalization of community structures

- Promote complementarity between community health workers (paid) and women leaders (volunteers).
- Maintain and enhance the commitment of women leaders through official recognition, continuing education and better coordination.

Sustainability of SAC and VSX

- Implement a specific sustainability plan for SAC including: continuous training of more service providers, integration into the Ministry's budgets/plans, sustainable contracting with public/private structures, community and institutional advocacy against conscientious objection.
- Diversify SAC providers and scale up legal and institutional advocacy to remove barriers related to conscientious objection.

Sustainable financing and transition

- Adopt a catalytic approach that contributes to the strengthening of the health system: targeted advocacy for sustainable financing and free care, strengthening administrative and financial capacities (DDS, MCZ, HC), possible use of a specialized consultant.
- Establish a post-intervention monitoring system to quickly detect any regression and adjust the strategy.
- Reassess the duration of MSF's commitment (beyond 2 years) and plan progressive interventions in peripheral areas to avoid overloading referral structures.
- Provide technical support for transition planning with concrete tools.

Global advocacy

- Engage in structured advocacy with the Ministry of Health to consolidate achievements, harmonize care protocols with the national system and secure the institutional recognition of community actors.

LESSONS LEARNED

Preparatory and targeted advocacy

- Integrate an awareness-raising and advocacy phase before the introduction of sensitive services (SAC, VSX, mental health) in order to reduce socio-cultural and institutional resistance.
- Ensure strategic alignment with mental health for comprehensive care

Sustainable community involvement

- Value the role of women leaders as a lever for community ownership and adherence. Their involvement promotes the gradual transformation of behaviour and strengthens the credibility of the system.

Planned and contextualized transition

- Successful sustainability requires a gradual transition that actively involves local/national authorities, COGES, service providers and communities.
- Importance of capitalizing on and disseminating local good practices (tricycles, community mechanisms) to feed institutional advocacy.

Systemic change

- The Couffo project illustrates the potential of a catalytic approach: positioning itself as a catalyst for systemic change by supporting the Ministry of Health and integrating the achievements into national mechanisms.

OBSERVED RESULTS AND CHANGES GENERATED

KEY FINDINGS

2.3.1. Follow-up of pregnant women

The rates of ANC1 performed in T1 of pregnancies in the HCs visibly and gradually improved over the duration of the project's implementation, despite an average rate in the HCs at about 60%, below the 65% targeted by the project. (H3.2. partially validated)

On average, 99% of pregnant women benefit from laboratory examinations at CPN1 (target 100%) and 97.23% of women who give birth in the HCs receive a mosquito net (target 100%). Despite these positive observations, on average, only 51% of pregnant women are protected by TD2 in the population (target 80%). (H3.2. partially validated)

2.3.2. Childbirth and neonatal care

In terms of ANC4 in Q3 (on average 35%) and deliveries by quality staff (on average 64%), the rates remain lower than those targeted by the project and no clear trend emerges on their progress. (H3.2. partially validated)

2.3.3. SAC VSX component and 2.3.4. FP

In addition to the standard FP services, SAC and VSX services were introduced after two years of socio-cultural preparation to build local trust, including through EVA workshops and technical trainings. Qualitative data seem to show increasing acceptance after initial resistance (H4.2. partially validated). There is no evidence that the

confidentiality and security of the SAC, VSX and FP services were in question (H3.3. cannot be validated). The data collected by the review do not clearly identify effects on these themes (H3.2 cannot be validated).

2.3.4. Mortality and morbidity reduction

At the level of the zone hospital, the review notes a decrease in the case fatality rate of direct obstetric complications and in the intra-hospital maternal mortality rate since the beginning of the project. (H3.1. partially committed, H4.1. cannot be validated).

FOLLOW-UP OF PREGNANT WOMEN

From October 2022 to March 2025, **the rates of ANC1 performed in the first trimester (T1) of pregnancies in HCs gradually improved over the duration of the project implementation (see Figure 1).** On average, in the first half of the project from October 2022 to December 2023, the ANC1 rate was 53% while this average rate increased to 66% in the second half of the project's implementation from January 2024 to March 2025. Despite an average rate of ANC1 in T1 in HCs at around 60%, below the 65% targeted by the project, the improvement trend remains visible as indicated by the linear trend line in Figure 2. The project seems to have contributed to a positive effect on the identification and early initiation of antenatal follow-up, even if the regularity over time remains to be consolidated.

A closer look at the sites visited by the evaluation team **shows positive progress in Lokogba and Tohou,** though rates >100% should be interpreted with caution. Lokogba recorded strong growth with a rate of change of +77% and an average of 55 ANC1/month. The curve shows a gradual rise to a peak around month 10, followed by stabilization. The coverage rate is also increasing (+80%), reaching an average of 66%, which marks a real and constant improvement in early antenatal follow-up. This could indicate a gradual increase in access to early monitoring in this area. Tohou also shows a notable improvement (+48%), with a lower average (40 ANC1/month), but a visible upward trend, despite some fluctuations. Tohou has an exceptionally high coverage rate, with an average of 101% (+44%), and several peaks well above 100%. Data quality is likely an issue, but it is important to note that the introduction of free ANC attracts many women from the neighbouring health zones of Ahodjinnako and Ahomadegbé to Tohou for ANC1. This high rate therefore reflects good performance but should nevertheless be interpreted with caution as it also reflects the concentration of demand.

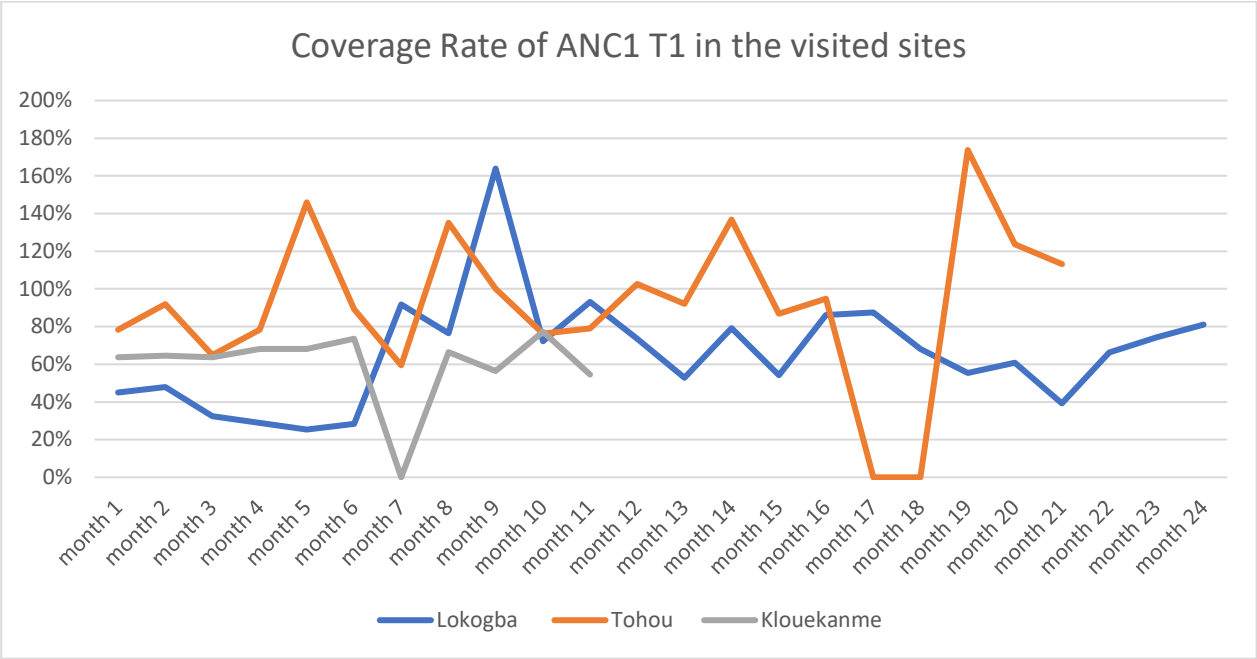


Figure 1: Coverage rate of ANC1 in T1 of pregnancy in three sites visited - Source: MSF internal data

Klouékanmè, which started from a higher level (average of 63 ANC1/month), shows a slight decrease of -3%. Klouékanmè shows a decrease in the coverage rate (-14%), despite an average equivalent to Lokogba (66%). This could indicate a stabilization of the service use, a stall linked to structural factors or saturation, or other.

At the level of ANC4 in T3, the rate remains below the 25% targeted by the project, with the exception of a few temporary peaks in 2025. The trend line is almost flat, suggesting little structural progress on monitoring through the third quarter. Several hypotheses could explain these relatively low rates, including the low cultural value of late ANCs once a confirmation of a "well-formed" foetus or the sex of the child is revealed, or the lack of clear information on the importance of the four complete antenatal visits.

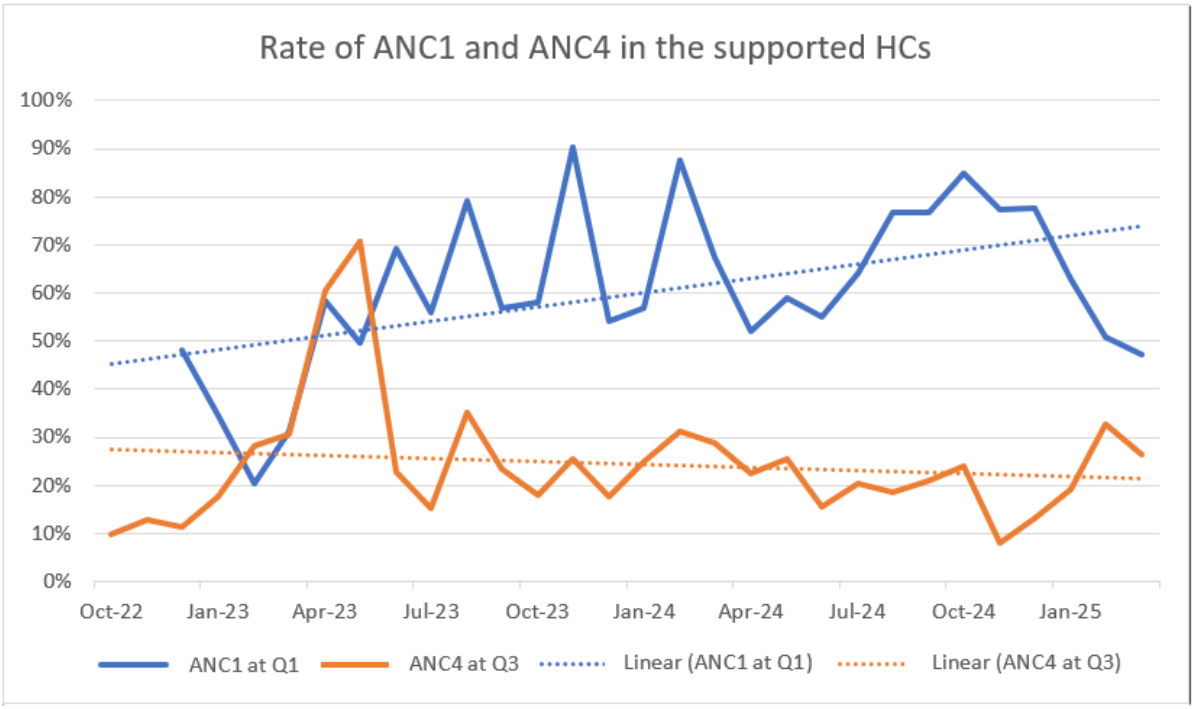


Figure 2: Rate of ANC1 and ANC4 in all HCs supported by MSF during the project - Source: MSF internal data

A closer look at three centres visited by the evaluation team reveals that the contribution of project activities to the observed results remains challenging. In Lokogba, there was a marked increase in the number of ANC4 (+144%) with a monthly average of 34 consultations. The coverage rate is also on an upward trend, averaging nearly 32 per cent, reflecting a gradual improvement. Lokogba posted solid growth, both in volume and coverage. This dynamic could indicate that the centre has succeeded in strengthening the continuity of antenatal follow-up until the last trimester. In Tohou, the absolute figures are unreliable. However, the increase in the coverage rate is impressive, with occasional peaks of up to 60%. On the other hand, Klouékanmè has an average of 29 ANC4 per month, but a significant drop in volume (-36%). Activity drops sharply after month 11. The coverage rate is relatively low (17%), despite an improvement of +75%, with a slight upward trend over the period.

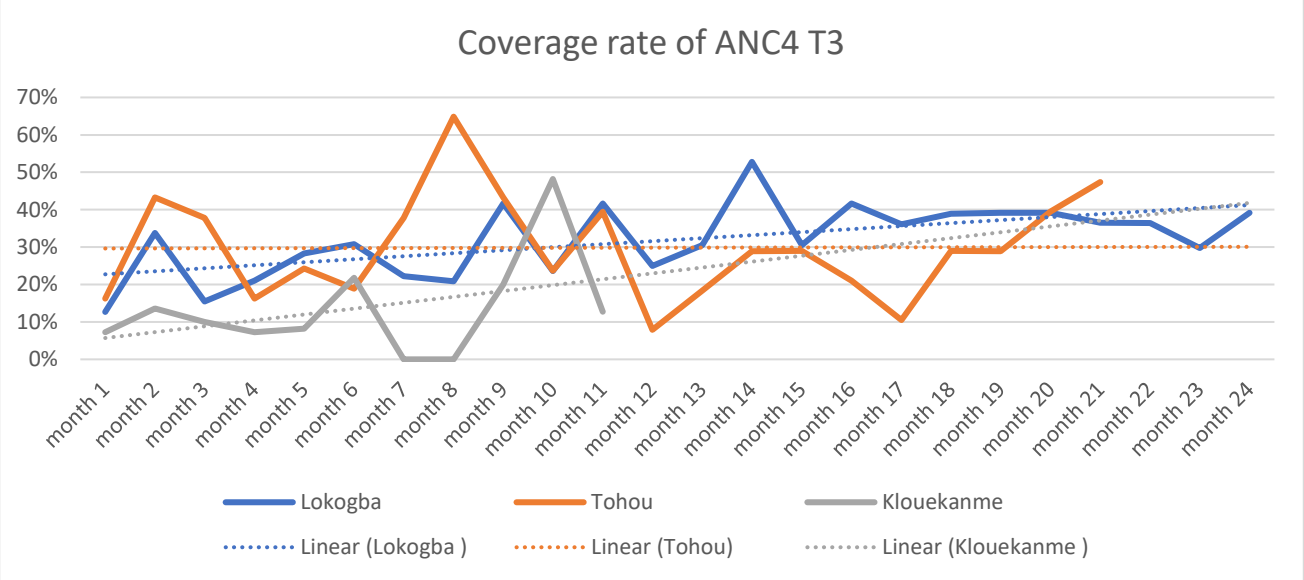


Figure 3: Rate of ANC4 at the T4 of pregnancy in three sites visited - Source: MSF internal data

The qualitative data did not reveal any factors internal to the project that could have discouraged the arrival of pregnant women and provided more explanations for the observed trends. MSF has taken concrete steps to remove financial barriers, including free care for ANC 1 and 4, as well as the introduction of incentives to encourage the completion of ANC 2.

> *"The free care, the distribution of birth kits to women, as well as the gifts offered on the occasion of the second antenatal consultation (ANC2) have strengthened the attractiveness of the centre. So much so that some people are now travelling from the neighbouring town of Toffo to be treated at the Tohou health centre."*[42]

Over the project implementation period from October 2022 to March 2025: **on average, 99% of pregnant women benefit from ANC1 laboratory examinations (target 100%).** This indicator is almost aligned with the target of 100% and has remained relatively stable, which seems to indicate a good overall functioning of initial antenatal screening at the HC level. In addition, on average, **97.23% of women who give birth in HCs receive a mosquito net (target 100%):**

> *"Many positive changes have been observed since the implementation of the project. In the past, access to immunization services was limited or non-existent. Today, vaccinations are carried out quickly and*

[42] Interviews with the men of the community

efficiently. […] In addition, women who give birth at the centre receive postnatal kits and mosquito nets, which enhances the quality of care and the well-being of mothers and newborns."[43]

This rate has changed little over the duration of the project to date, which could indicate a positive continuation of the integration of malaria prevention into maternal and newborn care provided. Despite these encouraging observations, on average, only 51% of pregnant women are protected by TD2 in the population (target 80%). However, this result should be interpreted with caution: the calculation of this indicator has been the subject of much discussion, as the methodology used did not always take into account doses administered in previous pregnancies, as should have been done. This methodological limitation, combined with possible operational challenges (monitoring between ANCs, stock-outs, loss of follow-up), helps to explain this still insufficient coverage.

LESSONS LEARNED

- Significant progress is possible on ANC1 when the offer is strengthened, care is free and communities are actively mobilized. This underscores the importance of combining support for quality service delivery with a targeted community engagement strategy.
- The difficulties in maintaining the continuity of follow-up until ANC4 illustrate the limitations of supply levers alone: cultural practices, beliefs around the third trimester, or the lack of information on the importance of complete ANCs can limit attendance, even when services are available and free.
- The suboptimal coverage of TD2 seems to highlight the potential challenges of coordination between the different components of the care pathway, and the need for better contact tracing, strengthening inter-consultation follow-up, and ensuring sustained logistics.
- The excellent coverage for nets and antenatal lab tests shows that some services that are well integrated into care routines can achieve and maintain high levels of performance.

CHILDBIRTH AND NEONATAL CARE

Strength of the evidence – Strong ☑

Over the period observed, about 64 per cent of deliveries were carried out by skilled personnel, slightly below the project's target of 65 per cent. After an initially very high level (close to 100% between October 2022 and February 2023), there was a marked decline from March 2023 onwards, with several months below 50%, including a significant drop in December 2024. However, these figures must be interpreted with caution: a rate of 100% seems unrealistic in a context where, in 2022, attendance at healthcare facilities was estimated at around 37%.[44] It is likely that calculation errors, data entry problems or a desire to present valuable data biased the first results. Therefore, it would be more relevant to analyse the progression over time and the trends observed, rather than considering the initial value as representative of reality.

[43] Interviews with female patients

[44] MSF internal data

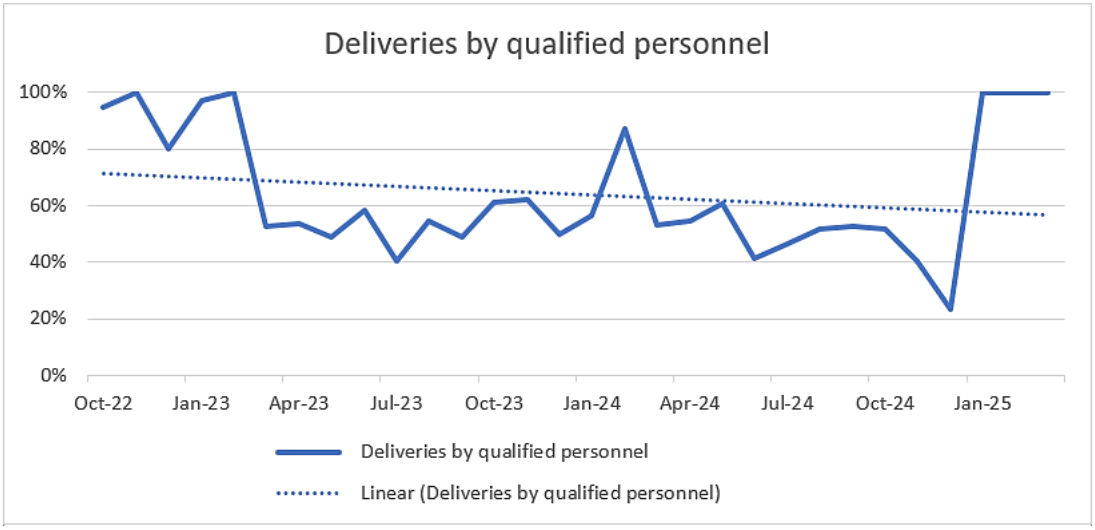


Figure 4: Rate of deliveries by qualified personnel in all HCs supported by MSF during the project - Source: MSF internal data

The rates of PNC2 and PNC 'other'[45] are gradually increasing over the current period of **implementation of the project, but overall, the rate remains below 35% over the majority of the period, which reflects a low postnatal coverage despite a dynamic of improvement**. The gradual progression could potentially reflect an improvement in the provision of services and follow-up to women after childbirth. To explain these relatively low rates, there may be a low prioritization of postnatal care, a lack of information or active reminders, and insufficient follow-up of women after discharge from the maternity ward.

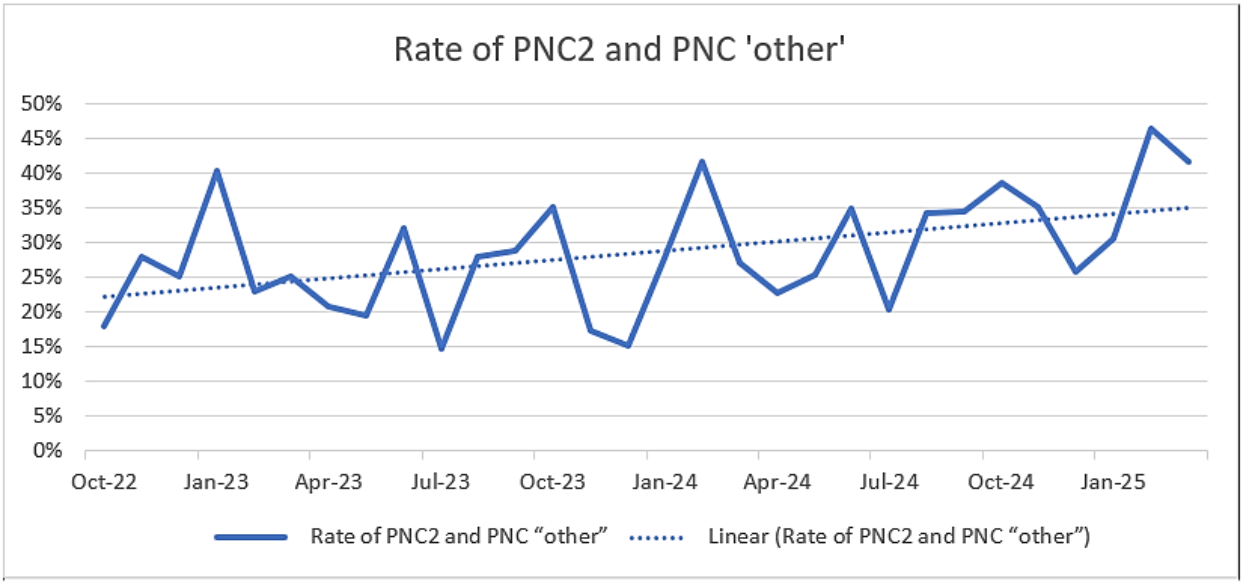


Figure 5: Follow-up rate of PNC2 and PNC 'other' in all HCs supported by MSF during the project - Source: MSF internal data

To further explore the contribution of activities to the observed trends, we analysed data from three HCs visited. In Lokogba, coverage rates are moderate but regular, generally varying between 25% and 45%, with a rate of variation of 142% over the duration of implementation. There is no data available for the first 6 months, but after that, the trend is relatively stable, with some peaks. There is no clear increase, but coverage is relatively stable, with an average rate of 32% and a moderate increase of +33%. The linear trend shows a slight improvement, but without any marked change.

[45] PNC 'other' refers to postnatal consultations occurring within 6 weeks after birth but not marked as PNC 1 or 2. Calculation formula seems slightly different from 2022-2025 so interpret the quantitative data with caution.

In Tohou, despite a very low start (0% in month 1[46]), there is a rapid increase, with high peaks: 65% (month 4), 75% (month 8), 78–80% (month 20–21). The general trend is upwards. The last 6 months show a stabilization at a high level, around 75–80%, which is remarkable. The average number of postnatal consultations is the lowest (13/month) of the three sites, but the area has the highest coverage rate (41%). The overall trend appears to be on the rise, despite significant fluctuations.

For Klouékanmè, the data are partial (up to month 11 only), but they show a constant progression, from 11% to more than 39%. Although the average rate remains lower than that of Tohou (27%), the trend is clearly upwards. Starting from very low or even zero levels, the area was able to maintain a high monthly volume of activity (34 CPON2/month).

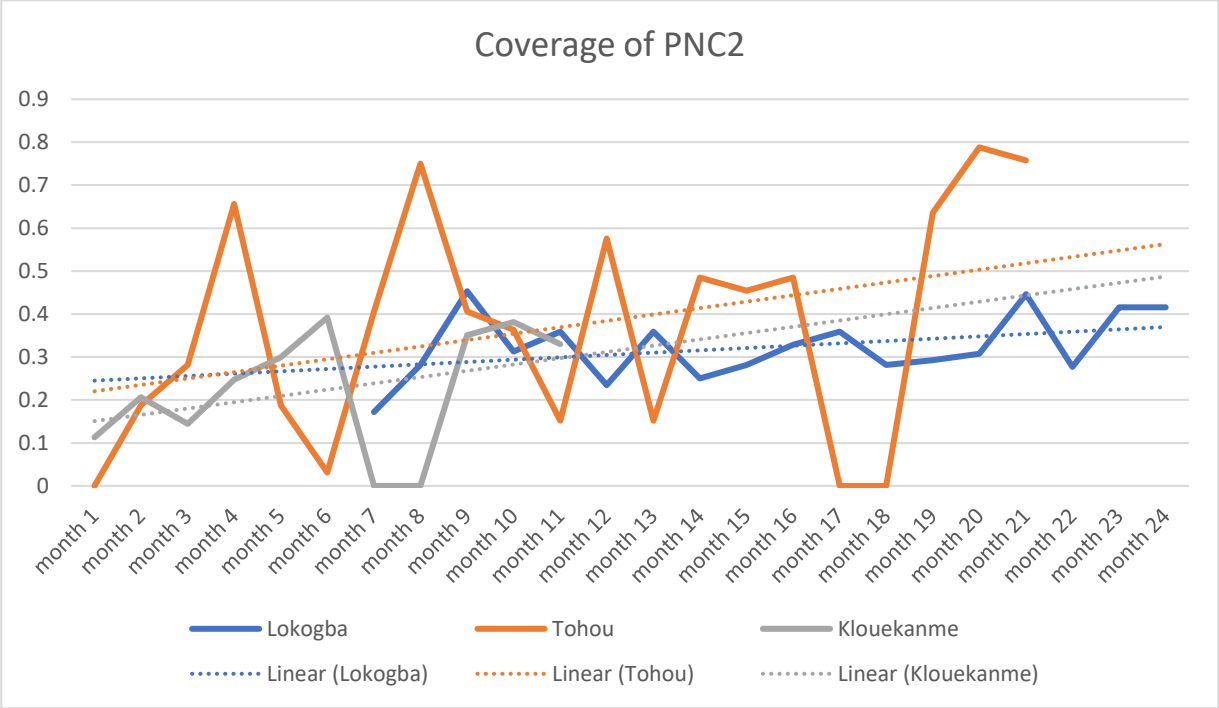


Figure 6: Rate of CPON2 in three sites visited - Source: MSF internal data

Overall, the analysis of data on childbirth and neonatal care in MSF-supported HCs shows encouraging, if mixed, results.

RECOMMENDATION

Strengthen the continuity of postnatal care by women leaders: Structure and support their role in home visits and follow-up of women after delivery, in order to increase the attendance of PNC and improve continuity of care.

[46] This could be related to data quality

LESSONS LEARNED

- Abrupt variations in indicators (e.g., delivery rates falling from 100% to 25% in a few months) suggest limitations in the data collection system. Investment in monitoring and evaluation capacity building, supervision and harmonization of reporting tools is crucial to improve data quality and its use for decision-making.

- The gradual improvement of PNC2 coverage in some sites (such as Tohou or Klouékanmè) suggests that community mobilization efforts, if sustained, can strengthen continuity of care after delivery.

SAC AND VSX COMPONENT

Type of services, care and community outreach

The implementation of safe abortion care (SAC) and management of sexual violence (VSX) in the Couffo project has followed a gradual trajectory, alternating phases of experimentation and strategic adjustments (Diagram 2). Initially planned from the start of the project, these services were only introduced in 2024, after almost two years dedicated to preparing the socio-cultural ground. This period, sometimes perceived as a "delay", can be explained both by a strategic choice by the MSF team aimed at establishing a climate of trust around sensitive themes such as FP, SAC and VSX, but also by the specific context of Couffo. Unlike other MSF projects where these services are introduced in the first few months, the weight of cultural and religious beliefs was particularly strong here, including among MoH providers, which required longer awareness-raising work. In addition, as MSF staff do not have direct contact with women, the integration of these services was largely dependent on mediation and the buy-in of MoH staff, which reinforced the importance of this preparatory phase. Thus, while this lag must be retained in the analysis, it also reflects a contextual adaptation aimed at maximizing the acceptability and sustainability of the interventions.

Diagram 2: Temporal analysis of the SAC component (next page)

Timeline of the SAC component – Couffo project

2022-2023 – EVA exploration
- Participatory community sessions
- Identification of obstacles
- Elaboration of acceptable messages

2023 – Mobilisation of 'whisperers'
- Selection of 30 key leaders
- Training on SAC, confidentiality & communication

2023 – implementation of patient navigation
- Discrete accompaniment to SAC structures
- Guarantee of confidentiality

2023-2024 – Training & protocols in structures
- EVA sessions with care-givers
- Technical training of midwives
- Written protocols and SAC integration

2024 – Partnerships with private clinics
- Contract with local clinic (stopped in March 2024)
- Mapping and new partnerships

2024 – CNGOB Collaboration
- Promotion of the law on abortion
- Training and supervision of providers
- Workshop on conscientious objection

During this preparatory phase, MSF favoured more consensual interventions (ANC, safe deliveries, FP), while conducting EVA (Exploration of Values and Attitudes) analyses, mobilising 30 "Whisperers" from influential groups, and co-constructing culturally adapted messages.

At the community level, a discreet network of guides has been set up, guaranteeing confidentiality and respectful support. Community leaders, female patients, youth and religious relays played a key role in breaking taboos:

"As far as the SAC and VSX are concerned, we work in a very discreet way, we just give a contact to the woman who needs this service."[47]

At the level of health facilities, MSF organized EVA sessions to address prejudices, provided technical training to midwives on SAC protocols, developed standardized procedures and strengthened confidentiality rules. For VSX, synergies have been developed with SAC activities: training of caregivers in reception and medical management, awareness raising on consent, and advocacy with the National College of Gynecologists and Obstetricians of Benin (CNGOB) for the promotion of the law and the clarification of the legal framework.

Results observed on the use of SAC and VSX services

The qualitative analysis highlights a significant evolution in community discourse and behaviours. In areas where MSF has been present for several years, attitudes towards FP, SAC and VSX have shifted from initial resistance to growing acceptance:

> *"SAC and VSX are very sensitive subjects, but we are beginning to understand that it is to protect our women and girls."*[48]
>
> *"At first, we refused to talk about these subjects, but with the explanations of women leaders and health workers, we now agree to discuss and refer cases."*[49]

The available quantitative data are not sufficiently decisive to corroborate the results observed, even if they show a slight downward trend in cases of VSX reported in health facilities. However, this development must be interpreted with great caution. Indeed, when awareness increases and messages are well accepted, it is expected that more cases will present themselves in health facilities to seek care. A decrease in recorded cases does not necessarily reflect a real decrease in the phenomenon within communities, but rather may reflect limitations in the reporting or capture of cases by the health system. Therefore, this data cannot, on its own, serve as a reliable indicator of the evolution of VSX in the intervention area.

Facilitators of this change and associated outcomes

Several factors have favoured this evolution:

- **Structured community engagement**: mobilization of women leaders and “whisperers”, trusted relays to deal with sensitive subjects.
- **Adapted communication strategy**: co-construction of contextualized messages via EVA sessions.
- **Targeted free care**: removal of financial barriers for patients, strengthening trust and use of services.
- **Institutional advocacy**: involvement of the CNGOB to popularize the law on abortion and support providers.

These measures have contributed to a gradual change in social norms and a better acceptance of SAC and VSX.

[47] Interviews with women leaders

[48] Interviews with women leaders

[49] Interviews with the men of the communities

Barriers to change / conscientious objections

Despite these advances, significant obstacles remain:

Availability of SAC providers: refusal of several midwives to perform SAC due to conscientious objection, forcing MSF to use a private clinic (and then two partner clinics after March 2024). This dependence on voluntary service providers makes the supply vulnerable.

Insufficiently integrated mental health: lack of operational psychological support, limiting the overall management of survivors of sexual violence.

Logistical challenges: drug shortages sometimes requiring patients to travel long distances.

Persistent socio-cultural constraints: fear of caesarean section, taboos around contraception, early marriage and young girls dropping out of school.

Structural factors: youth unemployment, lack of leisure spaces, which encourage risky behaviour:

> "Many young people don't have a job, they spend their time in bars. This promotes early relationships and unwanted pregnancies. If we created sports fields or activities, it could keep them busy."[50]

Finally, the lack of knowledge of rights remains an obstacle to prevention and access to justice:

> "Women are not well aware of their rights in cases of violence. Even when they are beaten, they think it's normal. There should be sessions to explain the law and the possible remedies."[51]

The effective availability of SAC providers has proven to be a critical weak link in the intervention logic, as illustrated by the necessary use of a private clinic to compensate for the refusal of several midwives to offer these services due to conscientious objection. This partnership, interrupted for personal reasons in March 2024, has led to a mapping of private clinics and the signing of new agreements with two local structures. Despite these alternatives, the SAC offer remains vulnerable because it depends on voluntary service providers, which makes it a weak link in the intervention logic.

[50] Interviews with community leaders

[51] Interviews with community leaders

RECOMMENDATIONS

Diversify service providers to secure the SAC offer

Include private clinics, local NGOs, independent providers to limit interruptions related to stigma or conscientious objection.

Intensify institutional and legal advocacy

Raise awareness among health authorities and service providers to counter the excessive use of conscientious objection and guarantee the effectiveness of the law.

Implement a specific sustainability plan for SAC

Including continuous training and support for a wider number of service providers, formal integration into the plans/budgets/protocols of the MoH, and contractualization with local structures.

Capitalize on the experience of older sites

Document successes (increasing acceptance of FP, SAC, and VSX) and build on these achievements to accelerate adherence in new areas.

Engage Community Champions

Involve women users and male opinion leaders as champions to strengthen social acceptability and deconstruct resistance.

LESSONS LEARNED

- Postponing the introduction of SAC/VSX to first prepare the socio-cultural ground (EVA, co-construction of messages) promotes acceptability and reduces initial resistance.
- Exploring values and attitudes with caregivers and communities helps to remove biases and align practices and messages with the local context.
- The "whisperers" and community relays, chosen locally, create confidential and dignified channels for the orientation of patients on sensitive subjects.
- Conscientious objection and dependence on a few clinicians make the SAC offer fragile; without securing human resources, the chain of care is broken.
- The transitional use of private clinics fills gaps, but exposes the system to ruptures (departures, changes).
- Advocacy (e.g. CNGOB) and promotion of laws are necessary but insufficient without clear operational protocols, shared SOPs and training of teams.
- After about 2 years, FP/VSX become more accepted; in the new areas, reluctance persists and would require more continuous and intense monitoring.

FAMILY PLANNING

Strength of the evidence – Strong ☑

New cases of FP consultations by health centre remain very low overall, with only a few isolated peaks followed by rapid returns to low levels. On average, less than 1% (0.99%) of women who have given birth accept FP, compared to the project target of 5%. Immediate postpartum FP thus appears to be a particularly fragile link in the care pathway, with the ambitious target of 125 new cases per HC per month never being reached. The occasional increases observed could reflect specific campaigns, intensive days or data entry anomalies rather than a structural change. Several factors can explain this situation: lack of immediate supply, stock shortages, lack of confidentiality, limited hours, or even non-systematic advice in the delivery room or ANC. In addition, there are demand-side barriers, such as fears of side effects, the spouse's decision, or the weight of religious and socio-cultural beliefs:

> *"As far as family planning (FP) is concerned, the subject remains sensitive. Some men express reluctance, believing that contraceptive methods can cause side effects on women's health. They also criticize [women leaders] and community health workers for discussing these issues directly with women, without first consulting their husbands. According to them, this creates tensions, because it is then men who have to deal with the supposed consequences of side effects, care management, and the impacts related to birth spacing."*[52]

> *"I hate FP because of the side effects that upset women. […] According to tradition, the woman [must not] engage in irresponsible sexual behaviour and have an abortion as she wishes. We have a duty to ensure that these bad practices do not invade our community."* [53]

Finally, a key structural factor is that the supply depends mainly on the midwives of the MoH, as MSF is not on the front line to directly deliver these services, which limits its ability to influence the results.

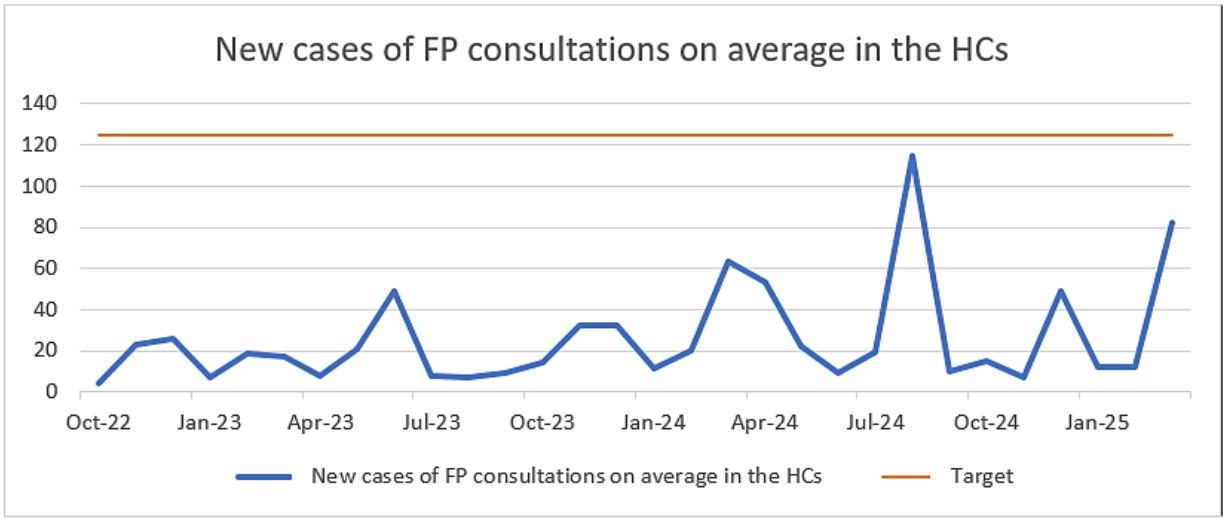


Figure 7: New cases of FP consultations on average in all HCs supported by MSF during the project - Source: MSF internal data

More specifically, in the three sites visited during the observation visit, the data indicate a very low overall uptake of postnatal family planning in all areas. The monthly rates of women who have given birth who accept FP often remain at 0%, and the overall averages are extremely low: 1% in Lokogba, 2% in Tohou, 2% in Klouékanmè. In Lokogba, the rate remained at 0% for a large part of the period, with a few months where slight progress was observed (month 8 at 2.17%, month 19 at 9.37%, month 21 at 2.04%, etc.). In Tohou, the rate reached a few occasional peaks: 5.26% (month 4), 7% (month 6), 17.85% (month 7), 6.70% (month 11). In

[52] Interviews with the men of the community

[53] Interviews with the men of the community

Klouékanmè, a single month (month 11) indicates an adoption of 20%, the highest rate observed in the entire series. No other month exceeds 0%, suggesting a very isolated action, potentially tied to a specific campaign or one-time opportunity.

In Lokogba, the start was slow but, from month 15, there was a continuous and significant increase, peaking at 170 new consultations in month 23, a record for this area. This increase brings the monthly average to 29, and reflects a gradual catch-up of the centre in terms of family planning.

In Tohou, FP activity is more regular, with a monthly average of 32 consultations. The curve shows several periods of intensification, at month 5 (60 consultations), at month 10 (106), then at month 14 (108), followed by temporary declines.

In Klouékanmè, the data reveal a particularly sustained activity, with a monthly average of 57 new consultations, almost double that observed in Lokogba. The area recorded several notable peaks, particularly in month 4 (155 consultations) and month 8 (133).

REDUCTION OF MATERNAL AND NEONATAL MORTALITY AND MORBIDITY

Strength of the evidence – Strong ☑

Maternal and neonatal mortality and morbidity indicators show a positive trend at the zone hospital between 2023 and 2025, suggesting a partial contribution of project activities to these improvements. On average, 91% of women with obstetric emergencies are referred and treated to the HDZ, a result well above the project's initial target of 15% (source: MSF internal data). At the same time, the case fatality rate for emergency obstetric and neonatal cases decreased from 7% in January 2023 to 2.3% in March 2025, with stabilization observed towards the end of 2024, marked by more than six consecutive months at 0%. Even if some occasional peaks remain, this evolution reflects significant progress in care. However, it is important to remember that the international standard, also used by MSF, sets the target at a case fatality rate of less than 1% for emergency obstetric and neonatal cases (see EMONC indicators[54]). This underlines that, despite the improvements observed, further efforts are still needed to fully achieve international standards of quality in emergency obstetric care.

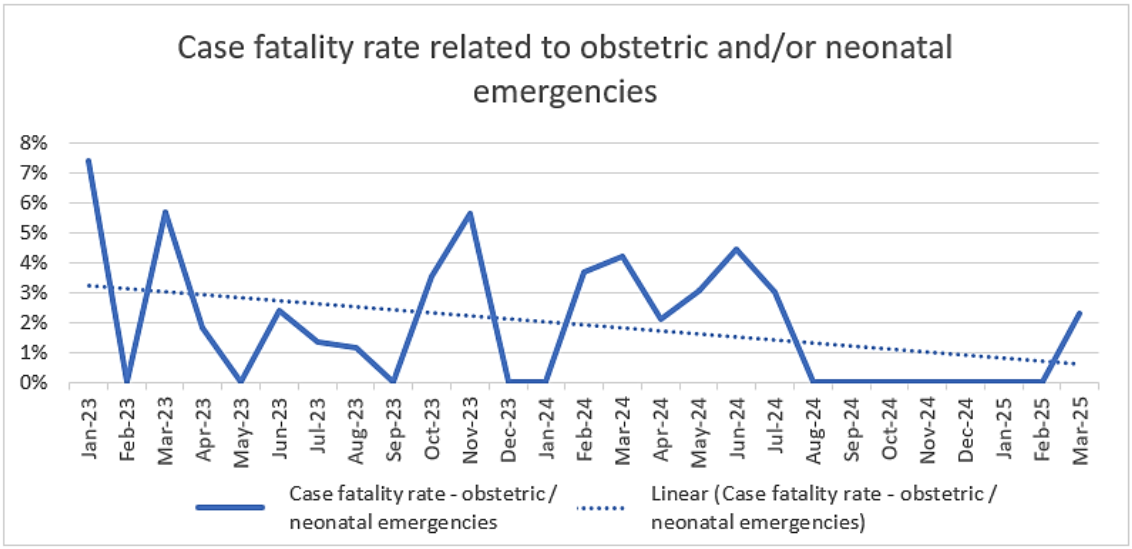


Figure 8: Case fatality rate related to obstetric and/or neonatal emergencies in HDZ - Source: MSF internal data

Despite in-hospital maternal mortality rates frequently exceeding the 0.5% rate targeted by the project at the beginning of the project, there has been a notable improvement from the end of 2023 at the level of the area

[54] https://emonc.org/en/framework/indicators/14/

hospital, which could suggest a possible contribution of the project to the gradual improvement of the quality of care in obstetric emergencies (see Figure 10).

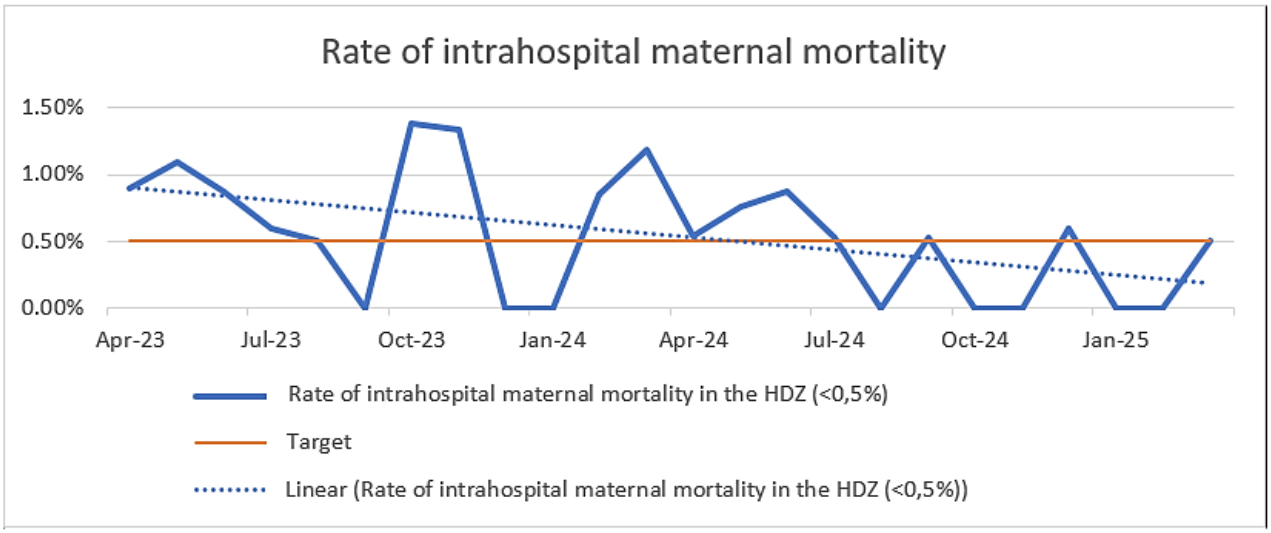


Figure 9: Maternal mortality rate in the hospital in the HDZ - Source: MSF internal data

Figure 11 shows the monthly evolution of the rate of early neonatal deaths (<7 days) in CEmONC activities at the MSF-supported zone hospital between April 2023 and February 2024. Overall, the rate remains below the 1% threshold set as the project's target. A few peaks exceed this target, but these increases remain isolated and short-lived, suggesting more circumstantial incidents than a structural trend. The analysis of the linear trend even shows a slight decrease during the implementation period, which can be interpreted as an encouraging sign of improved care. However, these results must be interpreted with caution because some of the most vulnerable newborns, including premature babies and cases of neonatal asphyxia, are referred to other facilities (Lokossa, Aplahoué, CHD de Zou). Available data in Lokossa indicate that between January and July, 122 cases were referred, including 41 deaths. For the other referral structures, no systematic feedback is available.

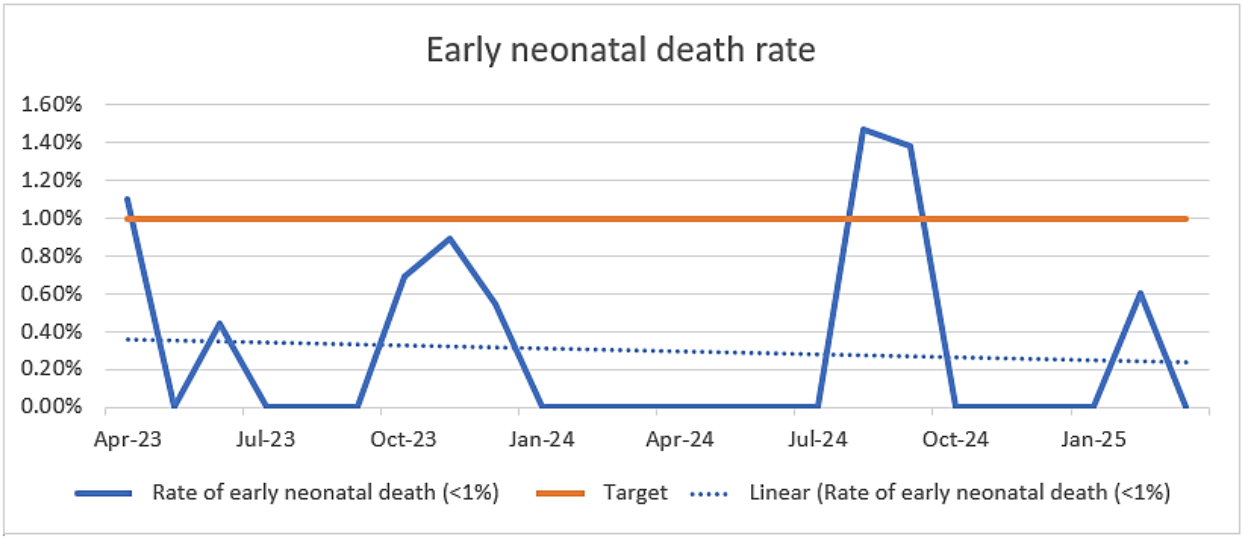


Figure 10: Rate of early neonatal death (<7 days) in HDZ - Source: MSF internal data

The qualitative data collected seems to confirm a contribution of the project's activities to the positive trends. 44% of respondents identified the reduction in maternal and neonatal deaths as the most significant change brought about by the project.

"Since MSF's intervention, they [community members] say they have not seen any neonatal deaths in their community. Women [...] now consider it a priority to go to the health centre at the first signs or needs."[55]

"Among the most significant changes observed since the beginning of the project are the reduction in neonatal deaths, the decrease in home births and a marked increase in the use of health services. Before the procedure, the health centre only recorded about two births per month. Today, this figure has risen to 30 to 40 monthly deliveries.[56]

These results, although to be interpreted with caution, suggest a gradual improvement in the key quality indicators of obstetric and neonatal care at the HDZ, and suggest a positive contribution of the Couffo project to the reduction of maternal and neonatal mortality in the intervention area. On the one hand, in addition to the basic neonatal unit installed at the zone hospital as part of the Couffo project, MSF has established a referral protocol for urgent and complex neonatal cases. This includes MSF fully covering the costs of transport and care, thus guaranteeing quick and free access to a more specialised level of care. However, on the other hand, various factors external to the project could explain these positive trends, such as a general strengthening of the national health system, an increase in the use of services thanks in particular to ARCH, the evolution of the epidemiological or contextual profile such as nutritional or environmental factors, changes in leadership or better management of the patient circuit, etc.

LESSON LEARNED

Referral protocols and free of charge have improved maternal and neonatal mortality and morbidity

A positive correlation is possible between the project activities and the improvement of the indicators for the reduction of maternal and neonatal mortality and morbidity in the HDZ during the implementation of the project activities, in particular thanks to new referral protocols and free transport and care established since the beginning of the project, which has facilitated a timely and opportune response to emergency obstetric and neonatal cases.

[55] Interviews with local authorities

[56] Interviews with the COGES

OPERATIONAL EFFICIENCY AND IMPLEMENTATION CHALLENGES

KEY RESULTS

2.4.1. Conscientious objection

Despite a favourable legal framework and EVA workshops, the SAC offer remains limited in part due to the majority of conscientious objections among midwives who have medico-legal fears and feelings of insufficient training. (H1.4. validated, H2.5. not validated, H4.2. not validated)

2.4.2. Challenges in managing tricycles

Referral tricycles equipped with a driver and fuel are highly appreciated, reducing home births and, indirectly, the risk of maternal and neonatal deaths. (H2.3., H2.7. and H4.1. partially validated).

However, the committees to ensure the operation of these tricycles are not systematically effective, which threatens the continuity of these services after MSF's withdrawal. The model in Tohou and Lokogba proves that structured community financing can sustain the system. (H3.4. partially validated).

2.4.3. Tensions in pharmaceutical management

Pharmaceutical management has come up against the national framework which imposes an exclusive supply, which has affected medicines/inputs. Following negotiations, MSF medicines have been partially integrated into the national system but are sold by HC pharmacies.

2.4.4. Consolidation of monitoring and evaluation mechanisms

The M&E system is functional but fragmented, resulting in data dispersion and difficult consolidation, which affects the overall readability of the results.

Collection by midwives seems to improve clinical relevance but still requires validation in the face of inconsistencies, whereas the IPC shows good digital practice with digitized and automated collection.

2.4.5. Lack of feedback to COGES

Some stakeholders expressed a sense of low involvement in MSF decisions (selection of women leaders, staff, monitoring of activities), citing a lack of consultation and feedback.

However, documents and interviews with other actors indicate active collaboration and regular exchanges, inviting us to contextualize these perceptions in the light of local political dynamics and power relations.

MSF's Couffo project faces several operational and implementation challenges, which should be distinguished according to their nature. Some are MSF's own modus operandi, while others are systemic in nature, linked to the structural dysfunctions of the Beninese health system. The latter – such as human resource deficits, institutional weaknesses or insufficient funding mechanisms – are beyond MSF's direct responsibility and are the responsibility of the national authorities.

However, these systemic constraints severely limit the sustainability of the project's achievements and call for structural responses, requiring broader mechanisms for financing, governance and strengthening the health system. In this context, Couffo's experience invites us to consider MSF's role as a **catalyst for change** : beyond the immediate humanitarian response, the organisation contributes to opening up transition pathways by supporting local and national authorities, disseminating innovative practices and creating the conditions for other institutional and development actors to take over. This catalytic posture could make it possible to better

articulate the urgency, institutional support and sustainability of the gains, without going beyond MSF's primary mandate.

CONSCIENTIOUS OBJECTION TO THE SAC RESTRICTING ACCESS TO THE SERVICE

Strength of the evidence – Strong ☑

Although Beninese legislation allows SAC under certain conditions, its implementation in the field remains limited, particularly in the health structures supported by the Couffo project. Indeed, midwives have the possibility of signing a conscientious objection form, which allows them to refuse to perform acts related to SAC. In practice, this provision is widely used: the majority of midwives choose not to offer this service, despite a proven demand within the communities. Figure 11 illustrates this finding:

Health Structure	Number of midwives	SAC
Zone Hospital Klouekanme	10	X
Klouekanme Health Centre	3	X
Toviklin Health Centre	2	X
Lalo Health Centre	2	X
Djotto Health Centre	2	✓
Tohou Health Centre	1	X
Lokogba Health Centre	2	X

Figure 12: Availability of SAC services by HC – Source: Observations, interviews with midwives, MSF staff interviews

The main reasons given are related to a feeling of insufficient training, as well as the fear of incurring liability in the event of medical complications or death, in the absence of legal protection perceived as clear or sufficient. This situation creates a vacuum in the SRH care offer. In addition, there are cases of stigma, such as that of the Grace Divine Clinic, which decided to discontinue the provision of SAC services due to social pressures.

To overcome barriers to the provision of SAC, the project team reoriented its advocacy strategy by targeting local health authorities, health care providers and community actors more directly. However, these elements reflect recent actions, implemented after the period covered by the review. They were shared with the evaluation team during discussions on preliminary results but could not be observed directly during site visits for the review.

In-depth discussions with the Departmental Directorate of Health (DDS) and the Medical Coordinator of the Health Zone (MCZ) have highlighted the barrier that the signature of conscientious objection represents for some providers. These discussions, coupled with direct meetings between providers and health authorities, clarified that conscientious objection should in no way be equated with a systematic refusal to offer SAC services. The authorities encouraged providers to follow protocols and provide these services in accordance with the law.

In partnership with the National College of Obstetrician-Gynecologists of Benin (CNGOB), the advocacy action plan has been enriched by the integration of targeted training sessions for midwives, organized in June 2025. These trainings aim to strengthen technical and ethical knowledge as well as understanding of professional

obligations, whether conscientious objectors or not. A total of 12 midwives and an obstetrical care manager were trained on the legal and regulatory framework for abortion in Benin, medical and professional ethics, referral and continuity of care, the consequences of unsafe abortion, human rights, and sexual and reproductive health and rights, as well as considerate professional communication.

At the same time, a mapping of private structures was carried out in the Klouékanmè area, leading to the signing of collaboration agreements with two health centers, located in Klouékanmè and Toviklin, to offer family planning, SAC and VSX services in an integrated manner, thus limiting stigmatization. The follow-up of women leaders was continued with a strengthening of the "whisperers" strategy. These efforts have made it possible to make SAC available in the health centres of Doko, Djotto, Tohou and at the Klouékanmè zone hospital. The next steps include the organisation of a values clarification workshop, facilitated by the central and local health authorities, to address persistent difficulties, including the systematic demand for additional examinations such as ultrasound before the provision of SAC, thus highlighting the need to harmonise care protocols.

This SAC component is a critical link in the intervention logic of the Couffo project. Indeed, the availability of trained, willing and empowered providers to offer SAC is a prerequisite for ensuring effective access to comprehensive and quality SRH care. However, the difficulties linked to conscientious objection, deviations from protocols and socio-cultural resistance make it a major point of fragility. Without this operational capacity at the level of health structures, the project's chain of intervention is weakened, thus compromising the achievement of the expected results in terms of reducing unsafe abortions and improving maternal health. The continuous strengthening of this link is therefore essential to sustain the quality SRH offer and ensure the sustainability of the project's achievements.

RECOMMENDATIONS

1. Diversify service providers to ensure an accessible and resilient SAC service offering

In order to secure access to SAC and limit interruptions related to stigma or conscientious objection, it is essential to diversify the providers involved. MSF could continue to look for potential partners — private clinics, specialized local NGOs, independent and licensed providers — that can deliver SAC services in accordance with quality standards. This strategy would broaden the geographical and social coverage of the offer, while minimising the risks associated with community stigmatisation.

2. Intensify advocacy to remove institutional and legal obstacles

At the same time, MSF should continue its strategic advocacy with the health authorities to ensure the effectiveness of the law on safe abortion. The aim is to counter the excessive use of conscientious objection by raising awareness among decision-makers, technical managers and SRH champions within the MoH. This advocacy should aim to clarify the legal responsibilities of providers, ensure their protection in the event of medical complications, and promote state-recognized continuing education. Finally, MSF could support the government in organizing a regular supply of medicines and necessary inputs to SAC, in order to institutionalize this service in the public health offer in the long term.

CHALLENGES OF TRICYCLE MANAGEMENT

Strength of the evidence – Strong ☑

The introduction of tricycles to facilitate the referral of patients from the communities to health centres (HCs) is one of MSF's most visible and appreciated responses to local requests. This initiative is recognized by the majority of respondents as a major lever in reducing home births and maternal and neonatal deaths: "*With the tricycle, pregnant women are taken directly to the centre to give birth, which has prevented several deaths.*"[57]. Indeed, the delays in accessing the HC, linked to the lack of transport and their cost to households before the introduction of the tricycles, constituted a high risk that women would give birth on the road and therefore without support from qualified personnel. MSF deployed tricycles (Photos 2 and 3) in the supported HCs, ensuring their complete management for the first six months (fuel, driver salaries, maintenance). A new tricycle management committee is then supposed to take over to guarantee the sustainability of the system.

Photo 2: Tricycle at the Klouekanmé HC

Photo 3: Tricycle at the Tohou HC

However, the review shows that in several sites, these committees have little or no function due to a lack of planning, leadership or clear funding mechanisms. This failure seriously undermines the sustainability of the strategy. In Klouekanmé, for example, the lack of an adapted management plan has led to the tricycle being almost unused: drivers, demotivated by the lack of pay, no longer answer calls — especially at night — and the vehicle is stationary due to lack of maintenance.

This is in contrast to other localities such as Tohou and Lokogba, where innovative local practices, including community-based funding mechanisms, have kept the service running beyond MSF's initial support.

In Tohou, to maintain the operation of the tricycle, the HC ensures the maintenance and oil change from its operating budget and has even planted a banana plantation (Photo 4) whose future income should contribute

[57] Focus group with female patients

to the financing of the tricycle. The district committee (District Chief and Village Chiefs) collects a weekly contribution from the members of the community to pay the driver and cover fuel costs.

Photo 4: Banana plantation in Tohou to sustain the financing of the tricycle

In Lokogba, the COGES budget had a line well before the Couffo project to cover the transport section of all the activities carried out outside the centre and towards villages that are difficult to access. After MSF's withdrawal, this budget line is used to ensure the maintenance of the tricycle.

> *"The project did not cover remote and landlocked villages. Maintaining the project's achievements will be difficult if the COGES does not commit to working for it. At the level of Lokogba, we use the tricycle for all SMNN activities, the COGES has identified in its budget a line to cover its operation."*[58]

The availability and operation of referral tricycles is a key critical assumption of the Couffo ToC. By ensuring the rapid transport of patients — especially for obstetric emergencies — to health centres, this system directly contributes to the availability and effective use of quality MNH and SRH services. However, the lack of sustainable management and funding mechanisms in several sites weakens this strategic link and risks jeopardizing the gains, especially after MSF's withdrawal. The successful experiences observed in Tohou and Lokogba, where innovative local solutions (community financing, dedicated COGES budget, income-generating initiatives) ensure the continuity of the service, demonstrate that it is possible to sustain this system even in contexts with limited resources. These good practices should be capitalized, documented and integrated into future strategies, in order to serve as models that can be transferred to other health centres to strengthen the sustainability of the referral chain.

[58] Interviews with the COGES

RECOMMENDATIONS

1. Strengthen the capacities of COGES for sustainable tricycle management

The COGES must be trained in the administrative, technical and financial management of the system, through practical workshops and the use of appropriate tools: planning frameworks, provisional budget models, maintenance protocols, and human resources management guides. This reinforcement will ensure real local ownership and prevent the failures observed. Increased responsibility on the part of the COGES, supported by a methodological framework, is essential to ensure that this transport solution is sustainable.

2. Capitalize on and disseminate local good practices to support community advocacy

The positive experiences of Tohou (financing via a community banana plantation) and Lokogba (budget allocation of the SC) show that endogenous and viable solutions can emerge to keep the referral tricycles in service. These initiatives must be systematically documented, analysed and transformed into accessible capitalisation tools, such as practical sheets or video testimonials. Their dissemination between zones through cross-visits or inter-community workshops will promote horizontal learning and mutual inspiration. By promoting these practices in spaces for dialogue with local authorities, MSF will also help strengthen the advocacy capacities of communities to defend sustainable funding models adapted to the local context.

TENSIONS IN PHARMACEUTICAL MANAGEMENT (BETWEEN THE MOH SYSTEM AND MSF)

Strength of the evidence – Anecdotal ☑

The management of medicines in the Couffo project has encountered constraints related to the national regulatory framework. The standards in force require that all medicines used in public health centres be supplied exclusively by the national purchasing centre. This obligation, initially, prevented the integration of the medicines supplied by MSF into the official distribution channel. A compromise was reached between the local health authorities and the MSF team so that the products could be distributed to health centres. However, health workers have been reluctant to distribute these stocks for fear of letting medicines from the national system expire in some of the project-supported HCs[59].

Following negotiations with the health authorities, an agreement was reached allowing the integration of MSF medicines into the national system. The stocks of MSF-supplied medicines were therefore handed over to the health zone's dispatch depot to be made available and sold by the health centres' pharmacy. However, their operational management is now beyond MSF's direct control, which limits its ability to ensure the logistical monitoring and traceability of these products. This situation introduces uncertainties about the continued availability of inputs, particularly in the structures supported by the project, and highlights the need for close coordination with the authorities to ensure the quality and regularity of supply.

LESSON LEARNED

In contexts where the supply of medicines is highly centralized by the state, the early integration of MSF into institutional mechanisms for planning and distributing inputs is essential. The initial lack of coordination highlighted the limitations of parallel procurement and underlined the need for a structured dialogue with the authorities from the design phase of the project. Active participation in needs estimates and a shared stock monitoring mechanism not only optimize the coverage of actual needs, but also strengthen the institutional anchoring of the intervention.

[59] Interviews with MSF staff

RECOMMENDATIONS

Strengthen coordination through MSF's participation in needs assessment

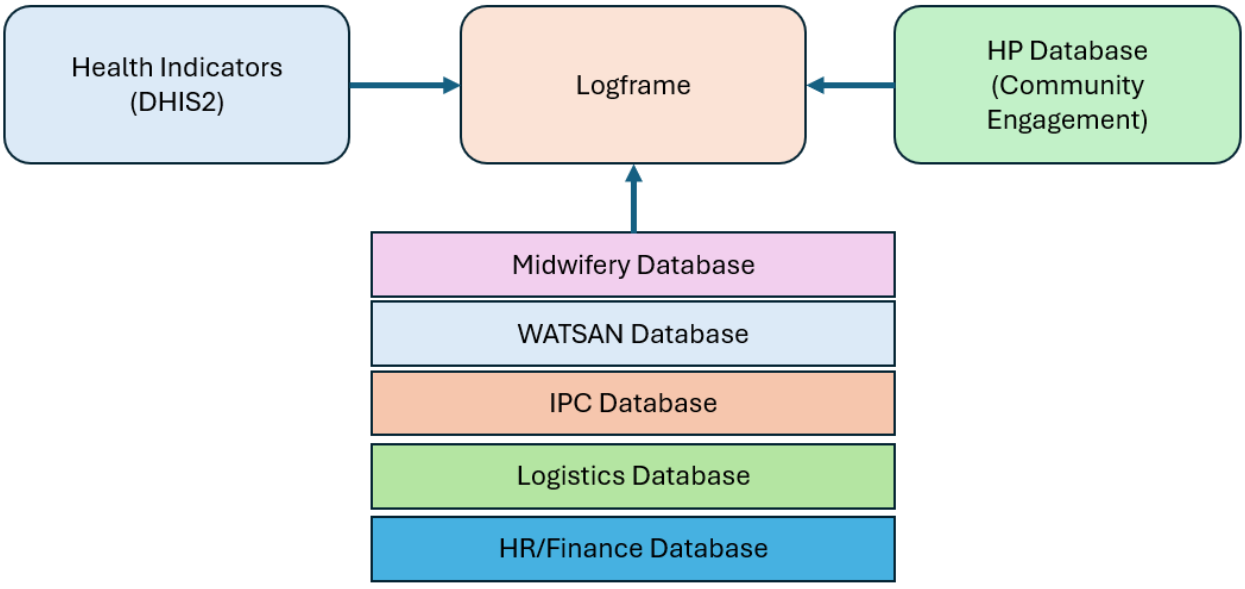
It is recommended that MSF be systematically involved in the sessions to estimate the needs for medicines organised by the health zone. This participation would allow for better planning and coordination in the distribution of inputs between MSF and the MoH, avoiding duplication or stock-outs. By being part of the process, MSF could adjust its contributions according to the quantities already planned by the national system, while ensuring that its own allocations meet clearly identified needs on the ground.

CONSOLIDATION OF MSF'S MONITORING AND EVALUATION MECHANISMS

Strength of the evidence – Strong ☑

The monitoring and evaluation framework of the Couffo project, although functional, remains fragmented and would benefit from being strengthened to improve the effectiveness of data management and the consistency of reporting. Currently, health indicators are collected through DHIS2 and integrated into the project's logical framework, while the Health Promotion (HP) team has its own database to track community engagement activities. In addition, there are specific databases used by other technical teams (human resources, finance, WATSAN, IPC, midwives, etc.), which also feed into monthly, quarterly and annual reports (Figure 1). This multiplicity of systems leads to a dispersion of data and complicates its consolidation, which limits the overall readability of the project results.

Figure 1: Couffo project data flow



Regarding data collection, a positive evolution has been observed. MSF has replaced low-skilled external data collectors with midwives themselves, who now transmit health indicator data directly to MSF's data team. This change improves the clinical relevance of the data, but still requires frequent back-and-forth for validation, in particular because of persistent inconsistencies (variations in calculation methods, deviations from one report to another, etc.). In contrast, the IPC (Infection Prevention and Control) team implemented an efficient digital

solution using KoboCollect for data collection, combined with a visualization platform powered by Power BI. This system enables automated calculations and near real-time visualization, while reducing human error.

This good practice demonstrates the potential of a project-wide digital monitoring system. Although this would require significant investment, the implementation of a centralised, configured and accessible online platform, with differentiated access rights controlled by MSF, would be a major step forward. Such a platform would not only improve the quality and reliability of data but also increase transparency and inform robust data-driven advocacy, including with local health authorities and partners.

A robust monitoring and evaluation system plays a key role in both the internal management of the project and its external scope. Internally, it provides real-time visibility into the progress of activities, quickly identifies operational obstacles or bottlenecks, and strengthens the traceability of responsibilities between different levels of implementation. It is thus a strategic management lever to adjust interventions in an agile and data-driven way. Externally, monitoring and evaluation feeds into advocacy efforts, helps to strengthen transparency vis-à-vis partners, authorities and communities, and makes it possible to value the results obtained. When well designed and integrated into practices, M&E becomes a key tool to improve the quality, accountability and impact of actions.

LESSON LEARNED

Fragmented M&E reduces data reliability, management effectiveness and advocacy capacity: The experience of the Couffo project shows that a fragmented M&E system limits not only the quality and reliability of data, but also the effectiveness of project management and advocacy capacity.

RECOMMENDATIONS

1. Consolidate databases into a single, integrated system

It is recommended that MSF review and strengthen its monitoring and evaluation system by centralizing all the databases currently dispersed (health, community engagement, HR, finance, WATSAN, IPC, etc.) in a single and coherent platform. This consolidation should be based on harmonised digital tools, such as KoboCollect, for data collection, and ensure a uniform structuring of indicators across the different components. Such an approach would not only improve the quality of the data, but also the consistency of periodic reporting, by limiting duplication, methodological discrepancies and loss of information between teams.

2. Set up an automated dashboard for monitoring and advocacy

This centralized database should be connected to an automated dashboard, such as Power BI, allowing the dynamic visualization of the project's key indicators. This system would offer near real-time monitoring, with automatic calculations and checks, thus reducing human error and facilitating rapid decision-making based on reliable data. In addition, such a platform would represent a powerful lever for advocacy: it could be shared with local health authorities or partners, guaranteeing secure and differentiated access according to profiles, and would highlight the results and impacts of the project in a clear and structured way.

LACK OF FEEDBACK TO COGES OR COORDINATION BETWEEN LOCAL ACTORS

Strength of the evidence – Anecdotal ☑

During the review, some stakeholders expressed, on an ad hoc but recurring basis, a feeling of low involvement on their part in some of the decisions taken by MSF, particularly with regard to the selection of women leaders, health personnel, or the monitoring of activities[60]. These grievances, highlighted in a single municipality where MSF is starting its operations, mainly focused on a perceived lack of feedback and consultation in the implementation of the project:

> *"In addition, the committee was not involved in the selection of women leaders supported by MSF. […] The COGES considers that, as a body with a political dimension, it should have been consulted. ".*[61]

However, the literature review and interviews with other stakeholders provide contradictory evidence of active collaboration and regular exchanges between MSF and these local actors.[62] It therefore seems necessary to contextualize these perceptions, taking into account the political dynamics and local power relations that can influence the feelings of certain interlocutors. These discrepancies underscore the importance of maintaining a transparent and structured dialogue with community stakeholders, in order to prevent misunderstandings and strengthen collective buy-in around the project.

RECOMMENDATIONS

1. Establish regular communication mechanisms with local actors

MSF should institute more formalized, regular and accessible communication channels. This would include, for example, quarterly feedback meetings with local stakeholders, presenting the results of activities, monitoring data, and ongoing strategic decisions. This type of system would make it possible to strengthen the inclusiveness of the project, to enhance the role of local structures in the governance of interventions, and to create a space for constructive dialogue to anticipate and resolve any misunderstandings.

2. Share selection criteria and decisions to enhance transparency

It is also essential that MSF clearly and transparently shares the criteria that guided sensitive decisions, such as the selection of women leaders or health personnel. This transparency would help defuse tensions, often fuelled by misunderstandings or rumours, and strengthen the ownership of the project by local actors. By making these processes clearer and accompanying them with explanations accessible to all, MSF would help build lasting trust with the health and community authorities, which is an essential condition for the sustainability of interventions and community buy-in.

TURNOVER OF MSF STAFF DURING THE PROJECT

Strength of the evidence – Strong ☑

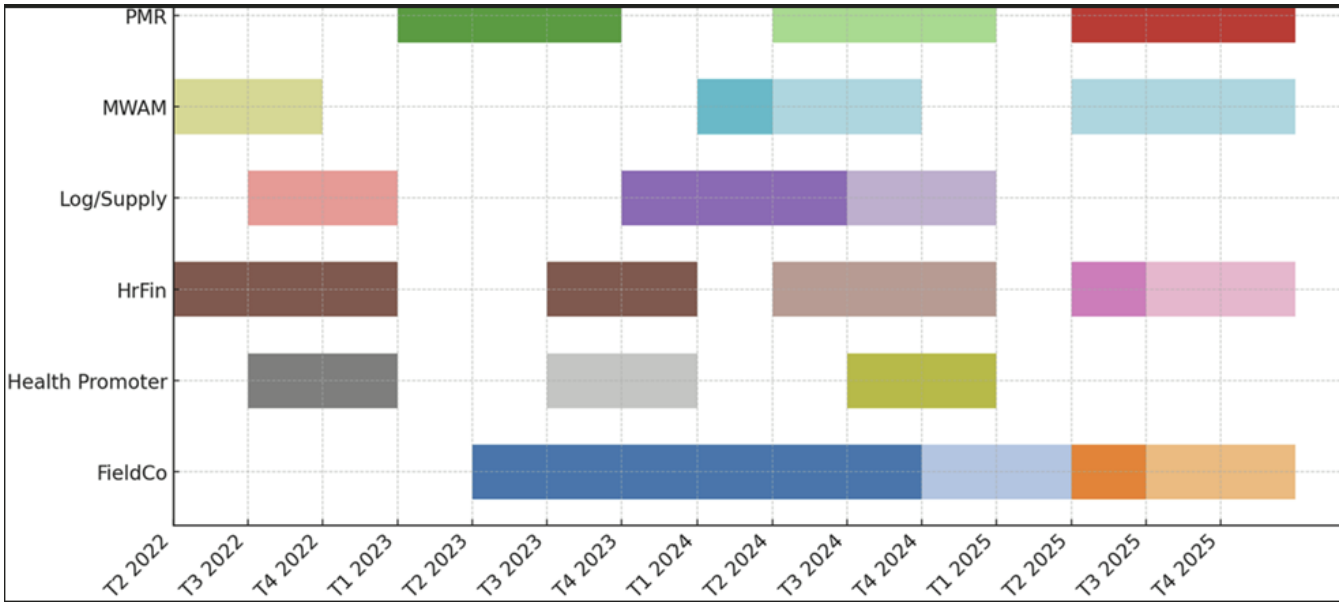
Several stakeholders – including representatives of local authorities, midwives, members of COGES and some MSF staff – have expressed concerns about the frequent turnover of staff during the Couffo project. Figure 2 illustrates this dynamic (with a different colour for a change of staff per position), highlighting regular changes in key positions as well as periods of temporary vacancy, which have occasionally led to discontinuities in operational monitoring.

[60] Interviews with local authorities and focus group with the COGES

[61] Focus group with the COGES

[62] Interview with MSF staff

Figure 2: Rotation of MSF staff in the Couffo project



Source: MSF HR team – each colour designates a different individual for each role

That said, while this turnover is inherent to MSF's operational model, several respondents also highlighted the ability of new teams to adapt quickly to the context, to take over ongoing cases and to respond effectively to emergencies. This adaptability helped limit the impact on business continuity. Thus, despite the concerns expressed, turnover was generally not perceived as a major obstacle to the overall performance of the project.

RECOMMENDATIONS

Consider longer assignments for key roles in medium/long-term change projects

In contexts where projects seek to strengthen systems and consolidate results over several years, a minimum of continuity in the workforce can be beneficial. Although rotation remains a feature of the MSF model, setting minimum durations for certain strategic positions could help to maintain the coherence of interventions and facilitate knowledge transfer.

Continue to strengthen the role and skills of national staff

Given that it is unrealistic to eliminate turnover entirely, greater investment in the recruitment, training and accountability of local staff remains a relevant strategy to mitigate its effects. Stable local teams that are well integrated into the context would be best placed to maintain relationships with partners, ensure business continuity and preserve gains beyond MSF's presence.

SUMMARY OF RECOMMENDATIONS AND LESSONS LEARNED

The results presented in Chapter 2 highlight useful lessons for other OCB projects in the areas of community engagement and collaboration with the Ministry of Health. These questions were themselves central to this analysis, and the lessons are summarized below.

SUMMARY OF RECOMMENDATIONS FOR THE COUFFO PROJECT

Result	Lesson Learned	Recommendation	Responsible
2.1 Appropriateness of the Project Design and Alignment with Needs			
2.1.1 Good alignment with maternal and newborn health (MNH) and sexual and reproductive health (SRH) priorities in Couffo	Tailor approaches to the specific maternal and child health needs of the local context Promote a holistic and integrated intervention model	N/A	OCB and Couffo project team
2.1.2 Inclusion of a relevant and effective community engagement model	Design an integrated community engagement strategy that is rooted in real needs Sustainably strengthen adherence to care through local engagement	N/A	OCB and Couffo project team
2.2 Implementation of activities and adaptation			
2.2.1 Infrastructure and Equipment Support	The rehabilitation and equipment of maternity wards have increased the quality, safety and attractiveness of care. Material support strengthens the confidence of users and the performance of structures. The absence of institutional relays for maintenance and financing threatens the sustainability of the gains.	N/A	OCB and MoH

2.2.2 Support for capacity building of health personnel	Combining training and regular clinical coaching works. Limiting support to a single group creates islands of competence, overload, demotivation and dilution of standards. Differences in status/remuneration (volunteers vs. non-supported staff) are fueling resistance.	Train all healthcare providers on MNH, VSX-SAC themes. Harmonize care protocols between MSF and the Ministry of Health. Set up regular refresher sessions.	Couffo project team and MoH
2.2.3 Financial and institutional support	Free care as a lever for access and trust. Limitations of the ARCH system and institutional fragility. Fragility related to staff pay. Need for a gradual and contextualized transition.	Consolidate targeted free access through local management mechanisms, community financing and equity of access. Strengthen administrative and financial capacities. Implement a post-intervention follow-up system. Define with the Ministry a duration of MSF support conditional on sustainable institutional milestones.	Couffo project team, MoH and OCB
2.2.4 Advocacy Support	Preparatory and targeted advocacy. Sustainable community engagement.	Institutionalization of community structures.	Couffo project team and MoH

	Planned and contextualized transition. Systemic change.	Sustainability of SAC and VSX. Sustainable financing and transition. Global advocacy.	
2.3 Observed results and changes generated			
2.3.1 Follow-up of pregnant women	ANC1 progress strongly when quality, free care and community mobilization are effectively combined. Follow-up to ANC4 remains limited by beliefs, cultural practices and lack of information. The low coverage of TD2 reflects challenges in inter-consultation coordination and follow-up. The high coverage of nets and biological examinations proves the effectiveness of well-integrated services.	N/A	Couffo project team and MoH
2.3.2 Childbirth and neonatal care	Extreme variations in indicators reveal weaknesses in the system of data collection and monitoring and evaluation. The increase in PNC2 shows that sustained community mobilization strengthens continuity of care.	Strengthen continuity of postnatal care through women leaders	Couffo project team and MoH
2.3.3 SAC and VSX Component	Delaying the introduction of SAC/VSX allows for socio-cultural preparation that promotes acceptability and reduces resistance. Exploring values and attitudes aligns practices and messages, while reducing the prejudices of caregivers and communities. Local “whisperers” and relays offer confidential and respectful guidance on sensitive subjects.	Diversify service providers to secure the SAC offer Intensify institutional and legal advocacy	Couffo project team, MoH and OCB

	Conscientious objection weakens the SAC offer, which depends on a limited number of clinicians. The use of private clinics temporarily fills the gaps but remains unstable and risky. Advocacy and promotion of the law requires clear operational protocols and continuous training. PF and VSX gain acceptance after two years, but remain contested in new areas.	Implement a specific sustainability plan for SAC Capitalize on the experience of older sites Engage Community Champions	
2.3.4 Family planning	Referral protocols and free care have improved maternal and neonatal mortality and morbidity		Couffo project team and MoH
2.4 Operational Efficiency and Implementation Challenges			
2.4.1 Conscientious objection to the SAC restricting access to the service	N/A	Diversify service providers to ensure an accessible and resilient SAC service offering Intensify advocacy to remove institutional and legal barriers	Couffo project team, MoH and OCB
2.4.2 Challenges in Tricycle Management	N/A	Strengthen the capacities of COGES for sustainable tricycle management Capitalize on and disseminate local good practices to support community advocacy	Couffo project team and MoH

2.4.3 Tensions in Pharmaceutical Management (between the MoH system and MSF)	The early integration of MSF into national procurement mechanisms optimizes the distribution of inputs. The initial lack of coordination revealed the limitations of a non-aligned parallel supply. Participation in forecasting and shared inventory monitoring strengthens coverage and institutional anchorage.	Strengthen coordination through MSF's participation in needs assessment.	Couffo project team and MoH
2.4.4 Consolidation of MSF's monitoring and evaluation mechanisms	Fragmented monitoring and evaluation reduces data reliability, management efficiency and advocacy capacity	Consolidate databases into a single, integrated system Implement an automated dashboard for monitoring and advocacy	Couffo project team and OCB
2.4.5 Lack of feedback to COGES or coordination between local actors	N/A	Establish regular communication mechanisms with local stakeholders Share selection criteria and decisions to increase transparency	Couffo project team
2.4.6 MSF staff turnover during the project	N/A	Consider longer assignments for key roles in medium/long-term change projects Continue to strengthen the role and skills of national staff	Couffo project team and OCB

CONCLUSION

The mid-term review of the Couffo project confirms the strategic and operational relevance of MSF's intervention in the Couffo department. In a health context marked by worrying indicators in MNH and persistent barriers to access to care, the project was able to effectively combine strengthening the clinical offer and structured community mobilization. This integrated approach, which focuses on both the quality of health services and community buy-in, has led to results in terms of reducing maternal and neonatal deaths, service attendance, continuity of care, and changing community perceptions of health behaviours.

The gradual introduction of sensitive components – including SAC, VSX care and psychosocial support – has shown the project's ability to adapt to local socio-cultural realities. The involvement of women leaders, trusted figures within communities, has proven to be a powerful lever for removing social barriers and promoting the use of services, including in the most sensitive areas. These achievements constitute a major added value and differentiate the Couffo project from more standardised interventions.

However, the review also highlights important challenges for the sustainability of achievements. Issues of human resources (replacement and retention of trained staff), logistics (management of tricycles, availability of inputs), financing (lack of sustainable mechanisms to ensure that the systems are free and functional), and social acceptability (resistance to SAC, persistent taboos) represent major vulnerability factors. These challenges, which are often systemic, go beyond MSF's strictly humanitarian mandate, but directly influence the sustainability of the gains.

Lessons learned underscore the need for a planned, phased and contextualized transition. This must actively involve local and national authorities, COGES, service providers and communities in order to consolidate the gains made before MSF's withdrawal.

The experience of the Couffo project also invites us to reposition the intervention as a catalyst for systemic change, going beyond the one-off strengthening of structures. This implies thinking of MSF's action as a trigger for institutional and community innovations, by further articulating a humanitarian approach with a view to contributing to strengthening the health system. This repositioning could result in:

Strengthening advocacy and financial sustainability

- Develop a targeted advocacy strategy with the Ministry of Health and partners to ensure sustainable financing of free MNH care, the integration of trained human resources and the institutional recognition of community actors (women leaders, community health workers).

Strengthening local institutional capacities

- Support DDS, MCZ and health centres in administrative, financial and logistical management, in order to secure the maintenance of infrastructure, the availability of inputs, and the continuity of services after MSF's withdrawal.

Harmonizing and integrating clinical practices

- Systematic alignment of MSF protocols with those of the Ministry of Health to facilitate ownership, reduce resistance and improve the coherence of care provision, particularly for SAC and the management of VSX.

Capitalizing on and disseminating local innovations

- Document and share successful experiences (community-based tricycle management mechanisms, referral tracking, role of women leaders) to nurture national and regional practices and strengthen local ownership.

Repositioning the project as a systemic catalyst

- Go beyond a one-off humanitarian logic by taking on a role in triggering institutional and community innovations, in order to contribute sustainably to the strengthening of the health system.

In concrete terms, this involves:

- An **adjusted duration of commitment** to consolidate the gains made before withdrawal.
- A **gradual extension** to peripheral areas to relieve congestion in referral structures.
- Integration **of harmonized digital tools** for monitoring and evaluation and data management.
- A **clear strategy for collaboration between community health workers and women leaders** to maintain their motivation and ensure the complementarity of the roles.

Finally, the review confirms that the success of the project is based on the combination of three key factors :

1. A reinforced and free care offer, adapted to the needs of MNH and integrating sensitive components with caution and progressiveness.
2. A deep and structured community commitment, based on credible local actors and on co-construction with communities.
3. Ongoing dialogue with health authorities, essential for strategic alignment and institutional integration.

For the next steps, MSF and its partners are faced with a strategic choice: to maintain a logic of essentially humanitarian support, or to fully assume a role as a catalyst for the transformation of the local health system. The review suggests that the second option, although more demanding in terms of resources and coordination, is the most likely to ensure the continuity, traceability and sustainability of the results obtained in Couffo.

APPENDIX 1: DETAILED THEORY OF CHANGE

Inputs

The inputs mobilised by MSF to initiate the project include:

- **Human resources**: MSF staff (expatriate and national), local health staff, women leaders (MVCs).
- **Material resources**: medicines, medical equipment, tricycles for evacuations, IEC supports.
- **Technical and financial support** : training, supervision, additional salaries, harmonized care protocols.
- **Institutional support** : agreement and commitment of the Beninese authorities (Ministry of Health, DDS, MCZ).

These resources have enabled a range of clinical and community activities tailored to the local context.

Activities

The main activities implemented by the project include:

- **Capacity building of** health personnel on BEMONC/CEMONC, SRH, SAC, VSX, mental health and IPC care.
- **Provision of free services** (ANC1 and ANC4, childbirth, SAC, VSX), with direct care or logistical support.
- **Deployment of tricycles** to ensure emergency obstetric referrals.
- **Community engagement** through women leaders including IEC, reminders, referrals, and postnatal visits.
- **Multisectoral coordination** with local health authorities, COGES and community structures.

These activities aim to simultaneously remove barriers to the supply and demand of care, by focusing on community anchoring.

Outputs

The expected outputs are the direct and immediate outcomes of the activities:

- **Reinforced health centres**, with equipment, trained staff, updated protocols and medicines.
- **Expanded access to** ANC, assisted delivery, family planning, safe abortion and sexual violence services.
- **Increased mobilization of communities**, through the active involvement of women leaders.
- **Functional referral and supervision systems**, including tricycles, medication management, and monitoring and evaluation.

These outputs improve the accessibility and perceived quality of services in MSF's coverage areas.

Outcomes

The intermediate outcomes are the medium-term outcomes of the project:

- **Increased attendance at services** (ANC, deliveries, SAC, VSX), including in remote areas.
- **Improved health behaviours** and community knowledge of SRH.
- **Reduction of delays in the care chain**, in particular thanks to tricycles and women leaders.
- **Strengthening local coordination** between MSF, the Ministry of Health, community structures and partner NGOs.

These changes show a positive impact on practices and the demand for care.

Final Outcomes (Impact)

The long-term ultimate outcomes are:

- **Reduction of maternal and neonatal deaths** in the intervention area.
- **Strengthening the resilience of community health systems**, in particular through the integration of women leaders and the sustainability of mechanisms.
- **Improvement of the capacity of local structures** (DDS, MCZ, COGES) to maintain the project's achievements after the withdrawal of MSF.
- **Institutionalization of good practices**, including the harmonization of protocols, the integration of providers, and the maintenance of a free and quality care offer.

APPENDIX 2: STRENGTH OF EVIDENCE MATRIX

Key results	Strength of Evidence	Comments
2.1 Design Appropriateness and Alignment with Needs		
2.1.1 Good alignment with SRH and MNC priorities in Couffo	**Strong**	Good triangulation of quantitative (MICS 2021-2022) and qualitative data with interviews with MSF staff and documentation (national strategy and policy on maternal and child health).
2.1.2 Inclusion of a relevant and effective community engagement model	**Strong**	Good triangulation of qualitative data with interviews with MSF staff, local authorities, health personnel, COGES, women leaders, women patients and men from the community.
2.2 Implementation of activities and adaptation		
2.2.1 Infrastructure and Equipment Support	**Strong**	Good triangulation of data with supporting project documentation and interviews with MSF staff, local authorities, health staff, COGES, women leaders, women patients and men in the community.
2.2.2 Support for capacity building of health personnel	**Strong**	
2.2.3 Financial and institutional support	**Medium**	Triangulation of qualitative data but with a lack of concrete documentation.
2.2.4 Advocacy Support	**Medium**	
2.3 Observed results and changes generated		
2.3.1 Follow-up of pregnant women	**Strong**	Good triangulation of quantitative and qualitative data with supporting project documentation and interviews with MSF staff, local authorities, health personnel, COGES, women leaders, women patients and men in the community.
2.3.2 Childbirth and neonatal care	**Strong**	
2.3.3 SAC and VSX Component	**Strong**	
2.3.4 Family planning	**Strong**	

2.3.5 Reduction of maternal and neonatal mortality and morbidity	**Strong**	
2.4 Operational Efficiency and Implementation Challenges		
2.4.1 Conscientious objection to the SAC restricting access to the service	**Strong**	Good triangulation of data with observations, interviews with health staff, MSF staff, local authorities, community leaders and women leaders.
2.4.2 Challenges in Tricycle Management	**Strong**	Good triangulation of data with case studies, observations, and interviews with MSF staff, local authorities, health personnel, COGES, women leaders, women patients and men in the community.
2.4.3 Tensions in Pharmaceutical Management (between the MoH System and MSF)	**Anecdotal**	Evidence limited to interviews with MSF staff without supporting documentation.
2.4.4 Consolidation of MSF's monitoring and evaluation mechanisms	**Strong**	Good triangulation between documentation, processes, monitoring mechanisms and interviews with MSF staff.
2.4.5 Lack of feedback to COGES or coordination between local actors	**Anecdotal**	Anecdotal report by some COGES and member of the MoH but with contradictory evidence from the project team.
2.3.6 MSF staff turnover during the project	**Strong**	Good triangulation between interviews with MSF staff, health staff, COGES and local authorities with supporting project human resources documentation (contracts).