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Formative Evaluation of the UNICEF Child Survival and Development program in The Gambia (2012-2021)

Final Report (September 2019)

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ACRONYMS AND ABBREVIATIONS

BReST	Building Resilience through Social Transfers for National Security in The Gambia
C4D	Communication for Development
CBC	Community Birth Companion
CHW	Community Health Workers
CLTS	Community-led Total Sanitation
CO	Country Office
COP	Community of Practice
CPAP	Country Programme Action Plan
CPD	Country Programme Document
CSO	Civil Society Organisations
CRR	Central River Region
CSD	Child Survival and Development
DHS	Demographic and Health Survey
DPT	Diphtheria, Pertussis and Tetanus
DRR	Disaster Risk Reduction
ECD	Early Childhood Development
EU	European Union
FGM/	Female Genital Mutilation/Cutting
GAM	Global Acute Malnutrition
GAP	Gender Action Plan (WCAR)
GDHS	The Gambia Demographic and Household Survey
GoTG	Government of the Gambia
HACT	Harmonized Cash Transfer
HePDO	Health Promotion and Development Organization
HIV	Human Immunodeficiency Virus Infection
IMAM	Integrated Management of Acute Malnutrition
IMEP	Integrated Monitoring and Evaluation Plan (IMEP)
IR	Intermediate Results
IYCF	Infant and Young Child Feeding
LGA	Local Government Areas
LRR	Lower River Region
MDFTs	Multi-Disciplinary Facilitation Teams
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MNCH	Maternal, New born and Child Health

MoBSE	Ministry of Basic and Secondary Education
MoH	Ministry of Health
MoWACSW	Ministry of Women's Affairs, Children, and Social Welfare
MoWR	Ministry of Water Resources and Fisheries
NaNA	National Nutrition Agency
NBR	North Bank Region
NBE	North Bank East region
OD	Open Defecation
ODF	Open Defecation Free
OECD-DAC	Organisation for Economic Co-operation and Development - Development Assistance Committee
PCR	Programme Component Results
PIC	Protection and Inclusion of Children
PIQSS	Program for Improved Quality Standards in Schools
PMTCT	Prevention of mother-to-child transmission
RHC	Regional Health Centre
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SAM	Severe Acute Malnutrition
SDG	Sustainable Development Goals
SMART	Standardized Monitoring and Assessment in Relief and Transition
SRH	Sexual Reproductive and Health
SRHR	Sexual Reproductive Health and Rights
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/Aids
UNCT	United Nations Country Team
UNDAF	United Nations Development Assistant Framework
UNDP	United Nations Development Programme
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
URR	Upper River Region
VDC	Village Development Committee
VHW	Village Health Workers
WaSH	Water, Sanitation and Hygiene
WB	World Bank
WCAR	West and Central Africa Regional Office

WFP	World Food Programme
WHO	World Health Organisation

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EXECUTIVE SUMMARY

1. Introduction

This report presents the findings, conclusion and recommendations of the independent formative evaluation of The Gambia **Child Survival and Development (CSD) program 2017-2021**, one of the two pillars of the UNICEF Country Programme implemented in the country (the second pillar is Protection and Inclusion of Children or PIC).

2. Purpose

The evaluation has **two purposes**:

- Accountability: to provide donors and expected beneficiaries with credible evidence on the extent to which the program attained its envisaged objectives ; and
- Learning: to inform the planning (and rectification as needed) of CSD-related activities amongst UNICEF, its governmental counterparts and the other partners involved in the implementation of the program, also through the integrating of good practices in their strategic and operational endeavours.

3. Objectives

The **objectives** of the evaluation include determining the relevance, efficiency, effectiveness, impact and sustainability of the program in supporting the Government of The Gambia to reach the vulnerable women and children in accessing and using quality health services, including nutrition; immunization; maternal and child health; prevention of mother to child transmission of HIV; and water, sanitation and hygiene (WaSH) services. It also involves the identification of lessons learned from the program; formulating recommendations on how to improve the implementation and performance; and assessing the extent to which the CSD program has integrated equity and gender in its design, implementation and monitoring.

4. Scope

The **chronological scope** of the evaluation is 2012-2021. The period between January 2012 and December 2016 corresponds to the previous UNICEF-CSD program; the period between January 2017 and May 2019 corresponds to the current Program. The **thematic scope** includes an assessment of vulnerable women's and children's access to, and use of interventions in the CSD program areas, namely health, nutrition, water, sanitation and hygiene (WaSH) and HIV, including prevention of mother to child transmission of HIV (PTMCT). It includes policy and guideline development, coordination, immunization coverage and disaster risk reduction at national level – and how these have contributed to the Sustainable Development Goals (SDG) and addressed inequities. **Geographically**, the scope was quite broad for the secondary data analysis (all activities implemented as part of the CSD program nationwide were reviewed as part of this evaluation). However, the field data collection took place in nine different sites in four of the country's regions that have been part of the program: Upper River Region (URR), Central River Region (CRR), Lower River Region (LRR) and North Bank Region (NBR).

5. Criteria

The evaluation has been guided by the **five OECD/DAC[1] evaluation criteria**: Relevance, effectiveness, efficiency, impact and sustainability. A total of eighteen **evaluation questions** (grouped by criterion) have been addressed in the course of this evaluation. Gender, human rights and equity issues are treated as cross-cutting issues throughout the report.

[1] Organization for Economic Cooperation and Development (OECD)/ Development Assistance Committee

6. Methodology

The evaluation rested on a mixed methods and participatory approach. The data collection **methods** consisted of a comprehensive documentation review, in-depth interviews, focus group discussions, two surveys and direct observations in the field. Quantitative data was analysed in descriptive terms; qualitative data was coded and common patterns were identified. As a result, the use of multiple lines of evidence was maximized. The **preliminary findings were presented and discussed with the CSD programmes key stakeholders on** 16th May 2019.

7. Key conclusions (by criterion):

Relevance

The CSD program is relevant in its policy alignment and unique role among the other UN and international agencies in working for child survival and development for children under five years of age.

Effectiveness

Regarding the previous CSD program (2012-2016), the information received points to elements of the program that were effective: vaccinating children against infectious diseases, promoting household behaviours and supporting the government in revitalizing the PHC strategy. Surveys in the field of nutrition reportedly led to evidence-based planning, assessment and policy advocacy. It was able to influence the policy level in areas that related to its program and succeeded in placing the spotlight on water and sanitation issues in its advocacy for girls´ right to an education, which through UNICEF-CSD´s continuous efforts have become an inter-ministerial issue.

The CSD has throughout placed emphasis on institutional development and staff capacity development for the various categories of government staff and volunteers in both programs – a very important element that cannot end due to the attrition within the government at all three levels, as well as the need for refresher training, and training of village and community volunteers assuming responsibilities for Maternal and Child Health (MCH) at field level. CSD has contributed to reduced child mortality and malnutrition in the country, however, the high rates of neo-natal mortality have not improved and therefore new strategies and more targeted efforts are needed in the coming years.

The new CSD program (2017-2021) has in its design placed more emphasis on "equity" and "behaviour change", and linked to the health outcome "rights" was added. In delivery, it has placed more focus than the previous on access to, and demand for, PHC services and water and sanitation facilities. The program is focused on "using" the VDC as an entry to the villages and communities and is active in coordinating efforts with the MoH and its close Partners in undertaking joint field assessments, spread messages and encourage demand for services. The evaluation has identified some issues that are critical: the absence of a gender analysis and gender integration in policy/plans; scarcity of voice from women, men, girl and boys reflected in the program documentation - regarding their perceived needs and constraints; the low participation of NGOs/CSOs and "champions" as partners in the implementation; lack of a strategy on how to reach children who are differently abled; and organisational boundaries between programs within the UNICEF Country Office, that are likely to reduce the level of effectiveness.[2] Finally, it was found that the health system is centralised, leaving the government actors at sub-national level not adequately empowered to make decisions on matters that concern their operations.

Efficiency

The evaluation has not had access to information and expenditure data to make a definite conclusion on efficiency. However, it can be concluded that the level of efficiency may not have been high. high. Although the boosting of financial allocations, human resources and expertise has taken place, it is

likely that the efficiency of the CSD program has been undermined by the Government's rather limited capacity to assign adequate and timely resources to the health facilities in the region (except for immunization).

Impact

Regarding the previous CSD program it is assessed that it has very likely had a positive impact in improving the health status of children under five, and reducing child mortality rates in the targeted regions. Impact at institutional level through knowledge sharing and building capacity of health sector staff is also likely even considering the attrition rate in the public health sector. However, not enough information has been available regarding impact in reducing neonatal and maternal mortality rates in the selected regions. As regards the current CSD program, it is assessed to be too early, at mid-term, to determine impact.

Sustainability

As the public health system, including the MoH, as well as the National Nutrition Agency (NaNA), is still dependent on support from development partners (donor agencies), sustainability cannot be determined as achieved. However, *certain domains* of intervention, such as child health, nutrition and WaSH have been increasingly integrated into government programmes, which suggests that such activities *could* continue even without UNICEF support, although at a much lower degree.

Gender, human rights and equity

The conclusion is that CSD´s attention to gender, human rights and equity is not sufficient. In the design of the program, the UNICEF current Program Document 2017-2021 (Section on CSD Program) mentions that is should be integrated in the program but does not explicitly propose any strategy on how this should be done. Equity is a term which is part of each of the three key Outcomes, but neither human rights nor equity integration are explained in the document. The previous UNICEF Program Document 2016-2017 (section on CSD program) is less specific on **gender** issues; Here, although women, children and mothers are specifically mentioned in the Programme Component Results (PCR) and progress indicators, curiously there is no mention of girls or boys. Thus, in both programs (current and previous), gender as a concept related to the needs of children (girls and boys), their mothers, adolescent girls, ***men and fathers*** - are hardly referred to in the documentation - *with the result of the latter not being sufficiently engaged during the programme implementation.*

Regarding **equity,** there clearly are differences in access to, and demand for services within the regions and no strategy exists as yet on how to provide services, and increase the demand, to children and mothers in the Non-PHC areas, or how to cater for the needs of children who are differently abled. Equitable access to vaccinations in the nation-wide immunization campaign also need to be improved. As for **rights** issues integration, the support to girls´ rights to an education is something the CSD has supported through for instance ensuring girls access to toilets, water and hygiene units – to counteract girls leaving school and entering marriage.

8. Lessons learned

These are the evaluation´s assessment on lessons learnt:

Lessons learned within Country Offices are often scattered and not systematically documented as they should. The UNICEF Guidelines for drafting a Country Office Annual Report (COAR) includes clear instructions on how to analyse and describe lessons learned. However, when scrutinizing the COAR from the past, very few explicit lessons were found. More lessons are generally documented in internal reviews[3]. The following are some lessons generalized beyond the immediate intervention being evaluated (CSD Evaluation for Gambia), most of which apply to UNICEF and its partners and stakeholders, even outside the country and region.

[3] Lessons are also mentioned in the IDR 2014, e.g. that UNICEF has a "comparative advantage through its downstream level attention" - and it should use its experience as evidence to advocate at policy level.

- All UNICEF Programs, and those of its Partners and key stakeholders (nationally, regionally and globally) would benefit from documenting its own lessons learned and ensure that there are internal and regional dialogue and sharing, specifically related to learning from implementation – including learning from what has worked and what hasn´t worked.
- Despite the push for convergence and inter-sectorial in CSD, the creation of separate sectoral outcomes (i.e. health, nutrition and Water Sanitation and Health - WaSH) in The Gambia CSD program is likely a result of lessons learnt from the previous program. A lesson that can be generalised beyond CSD is that this may be necessary for accountability reasons but that convergence between the "areas" must be dealt with so as to avoid silos as reported on here.
- The prevailing malnutrition issues and high mortality rates for neo-natals also triggered the UNICEF Program to push forward the UNICEF nutrition agenda to have a permanent nutrition specialist post in The Gambia for more technical expertise which also was the result of a lesson learnt and a very important in creating working relationships with for instance National Nutrition Agency (NaNA), and MoH. A lesson to be generalised beyond The Gambia is thus to ensure that the program´s outcome areas are matched with suitable technical expertise.
- While it is estimated that only around 1 per cent of the households still practice OD, in some riverine rural communities that have high water levels, communities experience difficulties in constructing and maintaining latrines which is not necessarily because of a lack of interest in the community to be declared Open Defecation Free (ODF) but has clear technical aspects to the problems. The lesson learnt that can be generalised beyond The Gambia is that social and technical problems related to water and sanitation issues with adverse effects on the health status of children (and families) are intimately connected, and therefore a holistic solution need to be sought in order to progress on health outcomes.
- Duplication of efforts in the government division of responsibilities for child survival were found to exist within the MoH.[4] Given the proximity of CSD and PIC staff within UNICEF and of the different Government agencies that work on health, nutrition and WaSH (that entails the risk of duplication of efforts), continued information sharing and communication are needed, both within UNICEF and between UNICEF and its other key partners and stakeholders.
- The involvement of CSD staff in joint field assessments of health facilities with the MoH colleagues has proved an important tool to strengthen the monitoring of the quality and quantity of the Maternal and Child Health (MCH) services offered in vulnerable regions. This is a lesson which easily can be generalised beyond The Gambia, and beyond the UNICEF and is an important learning for all UN agencies working with technical assistance with Government agencies.

9. Recommendations

The following are the strategic and operational recommendations based on the key finding and conclusions:

Strategic Recommendation 1 (aimed to Government of The Gambia: MoH, Ministry of Fisheries and Water Resources/MoFWR, MoWACSW and NaNA)

In close cooperation and with UNICEF support, and in cooperation with key UN agencies - develop a Community Health Policy and a Strategic Plan that clearly explains how MCH, Nutrition and WaSH services can be accessed by children and mothers who live in the remote Non-PHC villages, in areas with the poorest socio-economic and health status indicators, including Kuntaur and Brikama – in cooperation with and other key partners.

[4] This was triangulated and also presented and discussed in the Stakeholders meeting on 16th May in which the PS and many staff members of the MoH and others attended.

Strategic Recommendation 2 (aimed to UNICEF CSD and Government of The Gambia: MoH, MOFWR, NaNA)

a) Develop a strategy to build up a long term, involvement of NGOs/CSOs and private sector champions for social mobilisation and knowledge, specifically on CSD. This would require capacity development of potential organisations; and

b) Prepare for representation of informed CSOs/NGOs in technical working groups and joint field assessments.

Strategic Recommendation 3 (aimed at UNICEF CSD and management)

Address the issue of the institutionalised silo in the Country Office and promote more convergence and synergy around various parts of the CSD programme (Health, Nutrition, WASH and C4D). One way to tackle this is through creating a Community of Practice (CoP) that can cross organisational boundaries between CSD, PIC (and also the Program Effectiveness (PE)) – which would build on common interests, increase competences and enable knowledge transfer. Another way is to jointly (all programmes) create a Theory of Change (all sections).

Strategic Recommendation 4 (aimed to UNICEF CSD and Government of The Gambia- MoH, MoFWR, NaNA, MoWACSW)

Develop a strategy, including monitoring and follow-up, on how children and mothers who are differently abled may access and use health services.

Strategic Recommendation 5 (aimed to the Government of The Gambia – MoH, MoFWR, NANA, MoWACSW)

In close cooperation with UNICEF, develop tangible and measurable outcomes for delivering gender responsive messages to the public - including men (fathers, and to-be fathers), women, adolescents and children on how to prevent illness, child and maternal mortality.

Operational Recommendation 1 (aimed at UNICEF CSD)

Gather and document lessons from the field in a structured and systematic manner that give voice to girls, boys, women and men in the CSD selected vulnerable areas. The purpose would be to enable a more “informed" dialogue with the Government at policy level. This could be done through a participatory Reality Check Approach (RCA) and should involve voices (women, men, girls and boys) from the Non-PHC villages.

Operational Recommendation 2 (aimed to the Government of The Gambia)

Empower the sub-national actors (regional health Directors/health teams) in the Local Government Areas in terms of budgeting and decision-making in matters that directly concern their operations.

1 INTRODUCTION

This report presents the independent Formative Evaluation of The Gambia Child Survival and Development program 2017-2021 – which is one of the two program components of the overall UNICEF Country Programme implemented in the country.

1.1 Country context

The Gambia is a small country in West Africa, stretching 450 km inland along the Gambia River. It has a six km coastline bordering the Atlantic Coast and is surrounded by Republic of Senegal on the Northern, Southern and Eastern borders and the Atlantic Ocean on the Western border. Its population is around 2,187,264.[5] The country has two municipalities, Banjul and Kanifing and is divided into five regions: West Coast River region (WCRR), Lower River region (LRR), North Bank Region (NBR), Central River Region (CRR) and Upper River Region (URR). The Janjangbureg Local Government Area in CRR and the Basse Local Government Area in the URR show the poorest social indicators in comparison to the other regions, according to a UNICEF source in 2013.[6]

The Gambia is one of the most densely populated countries in Africa (176 people per square kilometre[7]) with an annual population growth rate of approximately 2.8 per cent during the last decade. An estimated 44.7 per cent of the Gambian population is below the age of 15 with the youth population (15-24 years) accounting for 19.5 per cent.[8] The majority of the population reside in urban and semi-urban areas. The GDP per capita is 483 USD making it one of the ten poorest countries in the world.[9] According to an estimate in 2010, the population living below the poverty line was 48.4 per cent.[10] In 2017, the Gambia ranked 174 out of 189 countries in the Human Development Index (HDI) report.[11]

In 2018, the GDP growth was estimated at 5.4 per cent, an increase from 3.5 per cent in 2017, mainly as a result from growth in the services sector, i.e. tourism, trade, financial services and insurance - which increased by 10 per cent in 2018. The transport, construction, and telecommunications sectors have also grown.[12] Tourism contributes by as much as 61 per cent to the GDP, while agriculture and industry account for 25 and 14 per cent, respectively.[13] Women are engaged in the horticulture sector and fisheries, representing 81 per cent of fish traders and 99 per cent of fish processors, and they participate in tourism and petty trading activities.

The informal economy constitutes a substantial part of the economy. The proportion of persons employed in the informal economy for both sexes is higher in the urban compared to the rural areas, as data shows that 63 per cent males and 66 per cent females in the urban areas are employed in the informal economy. For the rural areas, the proportions were estimated to be 37 per cent for males and 34 per cent females.[14]

UNDP´s Gender Inequality Index (GII), which reflects gender inequalities in three dimensions including reproductive health, ranks the country 173 out of 188 in the world.[15] The 2010 Women's

[5] Source: An estimate made by GAVI in 2018: www.gavi.org/country/gambia/
[6] Source: UNICEF Gambia website: https://www.unicef.org/gambia/overview.html
[7] Source: The 2013 National Census showed a population of 1,882,450 million. Source: UNICEF Gambia website: https://www.unicef.org/gambia/overview.html
[8] Source: Decent Work Country Programme, 2015-2017, The Republic of The Gambia.
[9] Source: World Bank 2017.
[10] Source: https://www.indexmundi.com/the_gambia/population_below_poverty_line.html.
[11] Source: hdr.undp.org/sites/all/themes/hdr_theme/country-notes/GMB.pdf
[12] Source: https://www.afdb.org/en/countries/west-africa/gambia/gambia-economic-outlook/
[13] Source: Article in ThePoint: http://thepoint.gm/africa/gambia/article/agriculture-contributes-25-to-gambias-gdp-in-2017
[14] Source: The Gambia Labour Force Survey (GLFS 2018) Analytical Report.
[15] Source: The GII is an inequality index. It shows the loss in potential human development due to disparity between female and male achievements in three dimensions, reproductive health, empowerment and economic status. Overall, the GII reflects how women are disadvantaged in these dimensions. The GII ranges between 0 and 1. Higher GII values indicate

Act was passed by the National Assembly in 2010, clearly laying out rights regarding economic empowerment, equity in employment, access to quality healthcare, equal educational opportunities and minimising the divisions between women and men in terms of socio-economic issues. The new Government of The Gambia claims that it has been left with a huge debt by the previous Government[16] - which is likely to be affect the health sector negatively.

1.2 Evaluation context

This section describes the Gambian health system and provides more details on the CSD program key areas: health, nutrition and water, sanitation and hygiene (WaSH). The report uses the following definitions for mortality statistics:

- Neonatal mortality: Probability of dying within the first month of life;
- Infant mortality: Probability of dying between birth and the first birthday;
- Child mortality[17]: Probability of dying between the first and the fifth birthday;
- Under-five mortality: Probability of dying between birth and the fifth birthday; and
- Maternal mortality rate: Annual number of deaths of women from pregnancy-related causes (per 100,000 live births).[18]

1.2.1 The Gambian health system

Due to the former government´s economic mismanagement of public resources, the new government under President Adama Barrow, which was installed in 2016, is burdened with debt servicing representing about a third of the Government´s annual budget.[19] The situation has had consequences for health care provision and essential services for children in the country.[20]

The MoH is responsible for health care delivery and provision of social welfare services in The Gambia. There are six Directorates under this ministry: Basic Health Services, Planning and Information, Social Welfare, Health Promotion and Education, National Public Health Laboratory and Human Resources for Health. The healthcare delivery and provision of social welfare services in the health sector are managed at two levels (central and regional levels). At the regional level, a Regional Health Director manages seven health regions.

The health system operates at primary, secondary and the tertiary levels, as follows:

At **primary** level, health care services are provided to villages that have at least 400 inhabitants by Village Health Workers (VHW), Community Birth Companions (CBCs) and other community volunteers. VHWs, most of whom receive some training, are assigned to identify acute malnutrition for screening and deliver primary health care in the village under their responsibility. Larger villages are served by Community Nurses who have clusters of primary healthcare villages to render services to. The Primary Health Care (PHC) is found to be weak and inadequately funded. Remote villages, referred to as Non-PHC villages, with fewer than 400 villagers, are basically not served. At **secondary** level, minor and major health centres provide health care, including private clinics. At **tertiary** level, health services are delivered by general hospitals, the Medical Research Council (MRC), several private clinics and some clinics run by NGOs.

higher inequalities and thus higher loss to human development. Source: UNDP Human Development Report 2016: http://hdr.undp.org/en/faq-page/gender-inequality-index-gii#t294n2918

[16] Source: https://www.theguardian.com/world/2017/feb/23/the-gambia-debt-theft-mismanagement-jammeh-allegations.

[17] Or it can be defined as "the number of deaths of children under five years of age in a given year per one thousand children in this age group".

[18] Neonatal, infant and under-five mortality rates are expressed as deaths per 1,000 live births. Child mortality is expressed as deaths per 1,000 children surviving to age one. Source: MICS 2018.

[19] The current National Development Plan 2018-2021 states "Economic mismanagement and massive theft by the previous regime has resulted in further fiscal shocks. Theft from State Owned Enterprises (SOEs) has been estimated at 4 percent of GDP per year since mid-2014." (Foreword by H.E. Adama Barrow, President of the Republic of The Gambia).

[20] UNICEF Annual Report 2018 (COAR), completed in 2019.

This three-tier framework is basically a sound system designed to enable primary health care services to be delivered at sub-national levels. However, limited resources (supplies and equipment), shortages of trained health personnel, high attrition rates[21], inadequate referral system, lack of decentralisation, low utilization capacity, weak supply chain and information management system[22] are problems that hinder health services delivery in the country at all levels.[23]

As the CSD program consists of three key program areas, the following sections will provide the reader with more contextually relevant information on each one of them, including the related statistical trends:

1.2.2 The CSD Program Area 1: Child and maternal health

The global picture - The reduction of **child mortality** is, and has been, one of the most important objectives of national health programmes in the world. Targets are set for reducing neonatal mortality to at least as low as 12 deaths per 1,000 live births and under-five mortality to at least as low as 25 deaths per 1,000 live births.[24] There has been great progress in child survival in the past few decades. In 1960 child mortality was 18.5 per cent and almost every 5th child born in that year died in childhood – however, in the last decades there has been a rapid decline of child mortality. [25] The under-five mortality rate declined by 56 from 93 deaths per 1000 (93/1000) live births in 1990 to 39 in 2017. [26] Child mortality has been continuously falling for the last 50 years in Sub-Saharan Africa (1 in 4 children died in the early 60s, while today it is less than 1 in 10).[27] However, despite such progress, about 5.4 million children under the age of 5 died in 2017 and about half of these deaths were in sub-Saharan African countries. In the neonatal period - in which children face the highest risk of dying - the average global mortality rate in 2017 was 18 deaths per 1000 live births.[28]

Immunisation has a very important role in achieving health and is found to impact as many as 14 out of the 17 Sustainable Development Goals (SDGs).[29] The proportion of the children who receive recommended vaccines has remained the same over the past few years.

Regarding **maternal mortality,** the SDG 3.1 aims at reducing (by 2030) the global maternal mortality ratio to less than 70 per 100,000 live births. Eliminating *maternal tetanus* is one of the strategies used to achieve this target. The vast majority of maternal cases (99 per cent) are occurring in developing countries and more than 50 per cent of these are found in Sub-Saharan African countries. In 2015, it was found that 216/100 000 occurred globally and 546/100 000 in Sub-Saharan Africa.

The Gambia – Ensure that a competent health worker with midwifery skills is present at every birth is the single most critical intervention for safe motherhood. There should be a referral system in place if emergency occurs to provide obstetric care in the right level of facility. Maternal mortality was estimated to be 400/100,000 in 2008, going down to 360/100,000 in 2010[30], and rising to 706/100,000 in 2015[31].

Table 1 shows that post-neonatal, infant mortality, child mortality and under-five mortality rates all have declined significantly. However, the neo-natal mortality rate in 2018 is persistently high with almost the same rate as 20-24 years ago, namely 31/1000 (which was 32/1000 in 20-24 years ago).

[21] Sources: The Gambia UNICEF Program Document 2016-2021; The Situational Analysis 2015, UNICEF; and interviews.
[22] Sources: Interviews, questionnaires.
[23] Source: In-depth Review of the Government of The Gambia and UNICEF Country Programme Action Plan 2012 – 2016.
[24] Source: MICS 2018.
[25] Source: *Child & Infant Mortality,* Article by Max Roser (https://ourworldindata.org/child-mortality.)
[26] Source: https://data.unicef.org/topic/child-survival/under-five-mortality/
[27] Source: *Child & Infant Mortality,* Article by Max Roser (https://ourworldindata.org/child-mortality.)
[28] Source: https://data.unicef.org/topic/child-survival/neonatal-mortality/
[29] Source: https://www.gavi.org/about/ghd/sdg/
[30] Source: CIA World Fact Book: https://www.indexmundi.com/g/g.aspx?c=ga&v=2223
[31] Trends in Maternal Mortality: 1990 to 2015 Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

Table 1: The Gambia child mortality rates survey data 2018[32]

Years preceding the survey	Neonatal mortality rate [1]	Post neonatal mortality rate [2] [A]	Infant mortality rate [3]	Child mortality rate [4]	Under five mortality rate [5]
0-4	31	10	41	17	57
5-9	28	15	44	19	61
10-14	34	17	51	29	79
15-19	33	31	63	53	113
20-24	32	33	65	54	115

Interestingly, in 2018 the data shows that urban areas have slightly higher rates (32/1000) of neo-natal mortality than rural areas (20/1000). In Kuntaur LGA the figure is 38/1000 and Brikama LGA (urban area) it is 35/1000 live births.[33] A number of factors are found to severely impact on child survival and health status such as malaria for children under five years, respiratory infections and pneumonia, diarrhoeal disease, malnutrition and sepsis in newborns - all preventable and treatable. Furthermore, the **vaccination coverage** in the Gambia is relatively high in comparison to countries in the region.

1.2.3 The CSD Program Area 2: Nutrition

Global picture - Nutritional status of children under age 5 is measured by wasting (low weight-for-height). Children's nutritional status reflects their overall health. Over the past decades maternal and child undernutrition and acute malnutrition has received much attention. Nutrition is identified as a major global priority as the numbers on prevalence of wasting in children under five years in the world are of great concern. In 2018, it was estimated that 49.5 million children under-five were wasted a figure that had not declined much from 2011, when 52 million were found to be wasted[34]. Sources also show that about one in four children under five years is stunted (26 per cent in 2011) and 80 per cent of the world's 165 million stunted children live in just 14 countries.[35]

The Gambia - Acute malnutrition has gradually decreased in the past two decades. In 2013 estimated that 12 per cent of children were wasted and 4 per cent were severely wasted. The highest levels of wasting was found in Basse and Kuntaur (17 percent and 16 percent, respectively)[36] which are areas where many households encounter food stress and food deficits in particular during the moths of July-September. The Multiple Indicator Cluster Survey (MICS) 2018 reports that 13,9 percent of the children in the Gambia are suffering from some kind of malnutrition of which 9,677 children are under 5 years. Children in rural areas are almost twice more likely to suffer from wasting compared to children living in cities. The recently published Micronutrient study report in 2018, states that the highest prevalence of malnutrition is found in Kuntaur, constituting a serious public health problem in that area.[37]

[32] Regarding child mortality, the evaluation had access to data from the 2010 Multiple Indicator Cluster Survey (MICS) 2013 Gambia Demographic and Household Survey (GDHS) and 2018 (MICS) on child mortality. *UNICEF has advised using the MICS data for consistency*.

[33] Source: MICS 2018.

[34] Source: The Joint Child Malnutrition Estimates, WHO, UNICEF, World Bank April, 2019 (Global level).

[35] *Improving child nutrition, the achievable imperative for global progress,* UNICEF report, 2013.

[36] Source: GDHS, 2013

[37] Source: National Nutrition Agency (NaNA)-Gambia, UNICEF, Gambia Bureau of Statistics (GBOS), GroundWork. Gambia National Micronutrient Survey 2018. Banjul, Gambia; 2019. The Micronutrient report refers to WHO, and the LGA.

1.2.4 The CSD Program Area 3: Water, sanitation and hygiene

Global picture - it is estimated that 2.1 billion people do not have access to safe drinking water services and 4.5 billion lack sanitation services that are safely managed. The impact on children´s health status and mortality rates is shattering as more than 340,000 children under five die every year from diarrhoeal diseases - directly related to poor sanitation, hygiene and/or unsafe drinking water. Regarding sanitation, management of human excreta that is unsafe, and lack of personal hygiene can cause diarrhoea and parasitic infections e.g. soil transmitted helminth (worms). Diarrhoeal diseases, soil-transmitted helminth infection and many other tropical diseases which cause misery to over 1 billion people worldwide could be reduced by a third if sanitation and hygiene are improved.[38]

The Gambia - Recent research (MICS 2018) indicates that 90,4 per cent of households have access to improved drinking water sources (compared to 89,6 per cent in 2013). The diseases related to lack of standards in the area of water, sanitation and hygiene account for 20 per cent of the under-five deaths in the Gambia. The majority of households (85 per cent) are found to have access to basic drinking water services which is reported to be an improvement from earlier years - but only 34 per cent use safely managed drinking water services. Disparities continue between urban (90 per cent) and rural (73 per cent). For instance, in Kuntaur LGA 66 per cent of population have access to basic drinking water services compared to Banjul where 100 per cent have access.

In respect to sanitation, the vast majority (99 per cent) of the households are estimated to be "open defecation free" (ODF)[39] and 62 per cent has access to improved sanitation. Only one third (31 per cent) of the household population has hand-washing facility with water and soap; and 73 per cent of households are at risk of faecal contamination of drinking water based on E. coli detected. The situation is worse for rural areas (92 per cent).[40]

1.2.5 Relevant policies and national strategies

The policies and national strategies that are the most relevant for the UNICEF-CSD program are:

- The National Development Plan (2018-2021);
- The Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Policy (2017-2026) that is aiming to set the standard for improved maternal health care and reduced infant deaths or child mortality;
- The National Health Policy;
- The National Health Sector Strategic Plan (2014-2020); and
- The global Sustainable Development Goals (SDGs).

Other relevant policies are the National Nutrition Policy (2010-2020) and the National Gender Policy (2010-2020) – the latter laying out guiding principles, distinguishing between gender equality and gender equity – stating that the Government is committed to eliminating all forms of gender inequality including in e.g. education and health sectors.

The Gambian Government´s launch of the *Nsaa Kenno*[41] approach with support of UNICEF is important as it aims to strengthen regional and local government structures and enhance the citizens

[38] Source: MICS Survey, 2018.

[39] UNICEF supported the implementation of a national ODF Action Plan, in the bid to reach ODF status by December 2017. Source: COAR 2016. ODF declared communities use an "improved sanitation facility, defined as one that hygienically separates human excreta from human contact. Improved sanitation facilities include flush or pour flush to piped sewer systems, septic tanks or pit latrines, ventilated improved pit latrines, pit latrines with slabs and composting toilets. "Open defecation" practice, on the other hand, includes disposing of faeces in fields, forests, bushes, open water bodies of water, beaches or other open spaces, or with solid waste." Source: The Gambia MICS Survey 2018, Survey Findings Report, November, 2018.

[40] Source: MICS Survey, 2018, and interviews.

[41] Nsaa Kenno ("We can do it" in *Mandika* language) was a project launched by the First Lady Barrow. It aims to strengthen regional and local government structures, increase people´s understanding of the rights of children, and the need for their

understanding of human rights, specifically the rights of children, and the need for their protection. Mobilising key actors is central for change as is engagement of young people. The approach includes provision of nutrition to children in the country and adopt the Local Government decentralised structures to enable programs to be more integrated than earlier.

protection. It is also designed to provide adequate nutrition to maximize the potential of children in the country. (source: https://allafrica.com/stories/201902010835.html)

2 EVALUATION OBJECT

2.1 UNICEF´s Child Survival and Development Program 2017-2021

The current UNICEF Country Program in The Gambia covers the period 2017-2021, with a budget of USD 23,6 M out of which USD 14,7 M comes from sources outside regular UNICEF resources. The annual budget amounts to around USD 6M and has more than doubled compared to the previous program. The overall country programme consists of two programs: i) Protection and Inclusion of Children (PIC); and ii) Child Survival and Development (CSD); For easy reference it should be noted that the term "Program" is herein used for the overall UNICEF Program, while "program" is used for the CSD and PIC programs.

As per the UNICEF Country Programme document (CPD), the **PIC program is expected to contribute to strengthening the child protection and social protection systems** to reduce violence against children and harmful traditional practices; making the education system accessible to all children, especially for children aged 0 to 6 years and those excluded from education, especially girls and children with special learning needs; and supporting the implementation of the new social protection policy.

The **CSD program, which is the object of this evaluation, is complementary to the PIC program and aims at attaining outcomes in three areas: health, nutrition; and water, sanitation and hygiene (WaSH). Its downstream activities are all directed to service delivery level to benefit the communities.** The Program is also expected to strengthening the following: (i) upstream policy advocacy; (ii) technical support and capacity building to key in-country stakeholders (iii) downstream community-based systems and services; and (iv) intersectoral collaboration and coordination at the community level.[42] Part of the Programme strategy is also to increase and strengthen collaboration between various sectors and coordinate activities at community level and to address issues in the geographical areas that are most in need but where also the greatest potential impact on the health and lives of children will be generated – the latter being part of UNICEF´s mandate.[43]

The current CSD program participants, also referred to as "beneficiaries", are the children under five years (girls and boys), adolescents[44], women who are pregnant/mothers/female caregivers to under-fives) nation-wide –with particular focus on this category residing in the regions with the poorest socio-economic indicators, namely North Bank River (NBR), Central River Region (CRR), Upper River Region (URR) (for the majority of its activities/interventions) - and Lower River Region (LRR) and West Coast Region (WCR) for some activities.[45] Regarding the immunization program, however, all children in the country are among its intended beneficiaries.

The CSD program constitutes about a third of UNICEF Gambia overall portfolio and is implemented at three different levels: national, districts and communities.

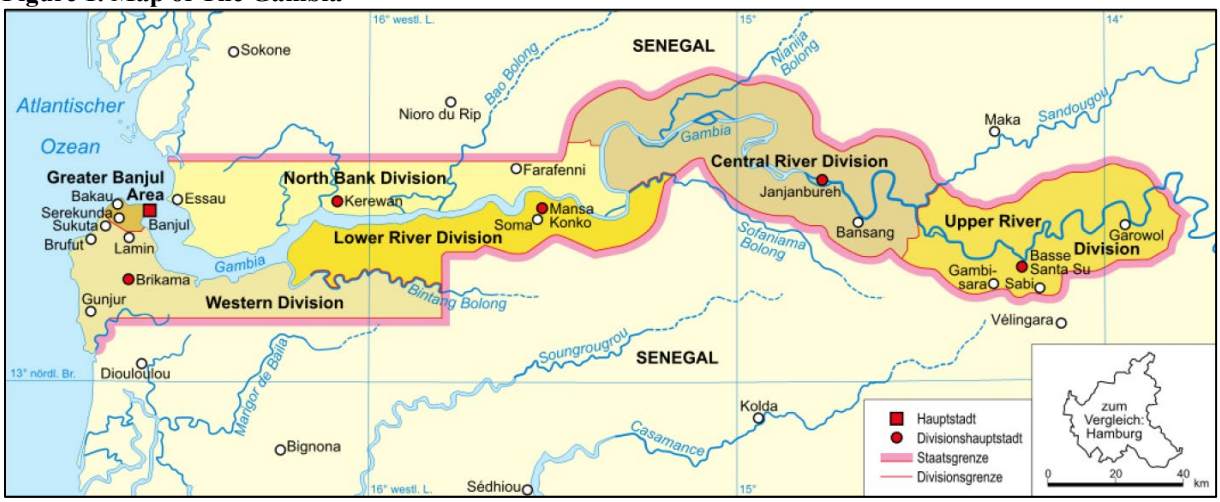
- At the national level, the program is implemented to support the primary health care strategy revitalization and related policies, and the implementation of Disaster Risk Reduction (DRR) and immunization interventions, as well as salt iodization nutrition policies, guidelines and coordination, PMTCT, and emergency response;
- At the district level, the program aims to improve the health services and the delivery of high impact health and nutrition interventions; and

[42] Source: UNCEF Programme Document 2017-2021 and ToR.
[43] Source: UNICEF Country Program Document 2017-2021.
[44] UNICEF defines adolescents to be in the age group of 10-19 years. Source: https://data.unicef.org/topic/adolescents/overview/.
[45] This has been informed by the UNICEF CO staff. The Program Document has not clearly spelled out who the CSD program participants (beneficiaries/target groups) are.

- At the community level, the program combines Communication for Development (C4D) activities with others aimed to support primary health care with essential drugs and supplies and Community-Led Total Sanitation (CLTS) activities.

CSD contributes to the following United Nations Development Assistance Framework (UNDAF) Outcomes: (i) Increased equitable access to quality health care for all (2.2); (ii) Increased access to equitable water, sanitation and hygiene for all (2.3); and (iii) Increased equitable and quality access to nutrition-specific and -sensitive services (2.4).

Figure 1. Map of The Gambia



Source: https://www.google.com[46]

The current CSD program has three intended outcomes and eight outputs as follows:[47]

Outcome 1. *Gambian children and women have access to and utilize improved and equitable quality maternal and child health services, learn and practice healthy behaviours.*

The following **outputs** are intended to contribute to Outcome 1:

- Output 1. Strengthened PHC system provides equitable and quality maternal and child health services specifically for under 5s, pregnant and lactating women - Including institutional capacities built to provide equitable and quality RMNCAH services;
- Output 2. A comprehensive RMNCAH communication plan is being developed (incorporating malaria, pneumonia and diarrhoea, PMTCT, immunisation, polio and child development) budgeted and implemented;
- Output 3. Village Health Workers are trained to implement integrated community case management; and
- Output 4. Targeted communities across the country acquire positive behaviour and demonstrate enhanced demand for health services with a particular focus on the neonatal period.

[46] Source: (full reference): https://www.google.com/search?q=map+of+the+gambia+division&tbm=isch&source=univ&sa=X&ved=2ahUKEwib_5Con5bkAhWLxosKHQvUDNwQ7Al6BAgDECQ&biw=1152&bih=577&dpr=1.25

Outcome 2. *Children, adolescent girls and women, especially the most vulnerable, realize their rights and utilize equitable and quality nutritional services and nutrition and care practices.*

The following **outputs** are intended to contribute to Outcome 2:

- Output 1. Institutional capacities are strengthened to plan and monitor for improved quality and equitable Integrated Management of Acute Malnutrition (IMAM), Infant and Young Child Feeding (IYCF) and micronutrient services including during emergencies; and
- Output 2. Supported communities demand for and practice optimal nutrition and care practices for children, with particular focus on recognizing and treating severe acute malnutrition.

Outcome 3. *Children and their families have improved and equitable access to and utilize safe drinking water and sanitation services and adopt improved hygiene practices and behaviours.*

The following **outputs** are intended to contribute to Outcome 3:

- Output 1. Capacity of WASH institutions at National and regional levels strengthened to plan, deliver, and monitor WASH services for underserved populations, schools, and health facilities including during humanitarianism situations; and
- Output 2. Caregivers and communities use safe drinking water and adopt adequate sanitation and good hygiene practices.

The program is lacking both a Theory of Change (ToC) matrix and a Logical Framework Analysis (LFA) matrix. The evaluator has constructed a *basic* LFA matrix (Annex XV). The UNICEF Country Program has provided a skeleton ToC with the following statements for the CSD program to build on further:

- Regarding **health,** *if* Gambian children and women have access to and utilize improved and equitable quality maternal and child health services and learn and practise healthy behaviours - *then* children will benefit from immunization and other preventive services, childhood diseases will be recognized and treated appropriately and maternal, neonatal and child mortality will be reduced.
- Regarding **nutrition**, *if* all children, adolescent girls and women, especially the most vulnerable, realize their rights and utilize equitable and quality nutrition services and nutrition and care practices - *then* the rates of stunting, wasting and micronutrient deficiencies will decline, especially among children in the first 1,000 days of life; children with severe acute malnutrition will be treated appropriately; and under-five mortality will be reduced.
- Regarding **WaSH***, if* girls, boys and women have improved and equitable access to and utilize safe drinking water and sanitation services and practise improved hygiene behaviours - *then* the overall rate of WASH coverage in communities and institutions will increase and childhood mortality and malnutrition rates due to diarrhoea and related diseases will decrease.

UNICEF implements the CSD program in **partnership with stakeholders** at different levels, mainly with the MoH, the Ministry of Fisheries and Water Resources (MoFWR), the National Nutritional Agency (NaNA) and World Food Programme (WFP).

- *At national level* the partners are Department Directors, managers and staff at MoH, MoFWR, NaNA and WFP, United Nations Population Fund (UNFPA), Joint United Nations Programme on HIV/Aids (UNAIDS), Food and Agriculture Organisation (FAO), World Heatlh Organisation (WHO), and the World Bank.
- At *regional level* the stakeholders are the LGA Directors and staff at the Regional Health Centres, Hospitals, Health Facilities, Nutrition Rehabilitation Centre (CREN) under the MoH.

- At *district and village level* these are the Village Development Committees (VDC), Village Support Groups (VSG), Multi-Disciplinary Facilitation Teams (MDFT) – which comprise government employed extension officers in different sectors - and Village Health Workers, Community Birth Companions (volunteers), children and teachers in Lower Basic Schools (and some Madrasas), among others. Also, community groups such as Water and Sanitation Committees and Mothers Clubs are involved to some extent at this level.

Working relationships have also been developed with donor agencies such as GAVI (the Global Vaccine Alliance) regarding UNICEF's role as grant manager, UNICEF and various bilateral agencies and National Committees that provide funds for various specific projects in the country. Very few NGOs are involved in the CSD program, specifically the Health Promotion and Development Organization (HePDO) and the Red Cross (during emergencies).

As already mentioned, this evaluation covers not only part of the Programme second phase (2017-2021) but also the entirety of it first phase (2012-2016). More details on the Programme first phase are provided below.

2.2 UNICEF's Young Child Development Program 2012-2016

The previous UNICEF's Country Program 2012-2016 had four key components, namely i) Basic Education; ii) Child Protection; iii) Social Policy, Knowledge and Advocacy; and iv) Young Child Survival and Development (YCSD) which was the forerunner of the current CSD program.[48] The then UNDAF Outcome "Improved access to quality basic social services with particular attention to the vulnerable and marginalized" was the long term goal.[49]

The Country Programme Action Plan (CPAP), the steering document for that Country Programme - supported a rights-based approach i.e. recognizing people as key actors in their own development. It outlined how UNICEF and the Government would work together to increase the understanding of children's rights in the country, to ensure that these rights are realized, and to mainstream gender equality in programming. The Program activities focused on the twenty most vulnerable districts in Central River Region North, Central River Region South, Upper River Region and North Bank Region.[50]

The YCSD program had Programme Component Results (PCR)[51]:

- PCR 1. By 2016, women and children in the most vulnerable districts have access to quality maternal and child health services, including nutrition, PMTCT and WASH, and especially during emergencies; and
- PCR 2. By 2016, an increased number of mothers and care givers in the most vulnerable districts have adopted essential care practices for child survival and development.

[49]Source: CPD Summary Results Matrix Gambia Office (an incomplete matrix).
[50]Source: IDR 2014.
[51] Each of the above-mentioned PCRs have numerous detailed indicators, baselines and targets for the planned provision of health care, nutrition, WaSH for pregnant women, mothers and children. Source: Program document 2012-2021, UNICEF. The term PCR is not used anymore in the current program but have been replaced by Outcomes.

3 EVALUATION PURPOSE, OBJECTIVES, SCOPE AND METHODOLOGY

3.1 Evaluation Purpose

The evaluation has **two purposes**:

i) **Accountability**, in providing evidence on the extent to which the CSD program reached its envisaged outcomes/objectives; and

ii) **Learning**, through the lessons to be identified and the evaluation´s recommendations. The latter is expected to enable the CSD program staff and Partners to adapt or modify the ongoing Country Program (2017-2021) to the specific needs in the country.

3.2 Primary intended users

The CSD program works in close proximity with just a few government agencies: MoH, being the key strategic Partner and the regional health centres under this Ministry in the selected program regions. On the government side, it also works rather closely with the MoFWR regarding its WaSH activities. NaNA is also a close Partner regarding its nutrition-related activities for outcome 2. From the UN side, WFP is an important partner regarding CSD´s nutrition and health related work. Other UN partners are WHO, UNFPA, FAO, WFP and UNAIDS, through the H6 Group partnership. The National Youth Council, the Red Cross and HePDO (the two latter being NGOs) have also been partners/stakeholders (please see more information about their contributions to the CSD program in section 4).

Table 2. Evaluation Users and Uses

Evaluation Users	Evaluation Uses
UNICEF CSD Section staff members	By better understanding the contributions of the integrated CSD section to The Gambia's developmental agenda, UNICEF will amend their CSD Programme Strategy, in concurrence with the mid-term review of the UNICEF country programme in 2019.
All UNICEF staff members	The corresponding use would be "to define a better coordination strategy with CSD towards the attainment of the different CSD outcomes" and "to identify the concrete modalities of strategic collaboration towards their attainment.
UN and other developmental partners (H6 Plus group: WHO, UNFPA, FAO, WFP, UNAIDS, UNICEF)	The CSD Section, in collaboration with all other partners involved in the implementation of the UN Development Assistance Framework (UNDAF), will introduce strategic implementation changes to their strategy for 2021 onwards.
Government ministries and agencies (MoH, MoFWR), NaNA, NYC	Will better define the terms of collaboration with UNICEF with respect to the attainment of the relevant goals set in the National Development Plan (NDP).
NGOs/CBOs	Mainstream (into their day-to-day practices) the good practices identified during the evaluation and address the weaknesses that have emerged in the course of the analysis.

3.3 Evaluation Objectives

The following are the four **objectives** of the evaluation:

i) Determine the relevance, efficiency, effectiveness, impact and sustainability of the CSD program in supporting the Government of The Gambia (herein referred to as the Government) to reach the vulnerable women and children to access and use quality health

services, including nutrition, immunization, Maternal and Child Health, PMTCT of HIV and WaSH services;

ii) Identify lessons learned about what worked and did not work about the CSD program including unexpected outcomes (positive and negative);

iii) Formulate key recommendations on how to improve the implementation processes and performance of the different projects implemented as part of continual learning process; and

iv) Assess the extent to which the CSD program has integrated equity and gender in its design, implementation and monitoring.

3.4 Evaluation Scope

The **thematic scope** of the evaluation includes an assessment of vulnerable women's and children's access to and use of interventions in the CSD program areas, namely health, nutrition, WaSH and HIV, including PTMCT. It also included determining the extent to which the CSD program has contributed to policy and guideline development, coordination, immunization coverage and disaster risk reduction at national level – and how these have contributed to the achievement of the Sustainable Development Goals (SDG) and addressed inequities (social, geographical and financial). At sub-national level, the evaluation determined the extent to which the health facilities and personnel are equipped with skills and supplies to effectively deliver high impact health and nutrition interventions. At community level, the evaluation would determine the extent to which interventions, such as the CLTS and the C4D program components have contributed to the reduction of childhood diseases, such as diarrhoea and malaria, and the adoption of key essential family practices and behaviours. Availability of supplies and the role of community structures that enable CSD implementation was to be looked into. The extent to which the Multi-Disciplinary Facilitation Teams (MDFTs) and VDCs were promoting key household behaviours was also part of the evaluation´s thematic scope.

The **geographical scope:** The secondary data review included activities implemented as part of the CSD program nationwide. However, the field data collection concentrated on a smaller sample of sites where UNICEF has implemented its CSD program activities, namely in nine different sites in URR, CRR, LRR and NBE region. For the purpose of lessons learned and in order to help guide the recommendations,

The **chronological scope** includes not only the CSD´s strategies implemented as part of the current Country Program (2017-2021) but also the CSD strategies implemented during the 2012-16 Country Program. More specifically, the evaluation covered the period between January 2017 and May 2019 of the current CPD, and January 2012 and December 2016 of the previous CPD.

3.5 Evaluation Criteria

The five OECD/DAC evaluation criteria were applied in the evaluation, namely relevance, effectiveness, efficiency, impact and sustainability. In addition, a gender, equity and human rights criterion was used. The list below outlines how these apply in the specific context of this CSD program evaluation:[52]

- Relevance refers to the extent to which CSD activities are in line with the priorities and policies of the national development agenda and key stakeholders as well as the (direct, indirect, ultimate) program participants (also called "beneficiaries") as well as UNICEF itself;
- Effectiveness is understood as the extent to which strategies and activities contribute to meeting the stated CSD-UNICEF key outcomes;

[52] These are the OECD-DAC evaluation criteria for evaluating development assistance. Source: https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm

- Efficiency entails determining whether the least costly resources possible were used to reach the intended results;
- Impact is understood as identifying any key positive and negative changes generated through the implementation of the CSD program (directly or indirectly, intended or unintended);
- Sustainability is understood as the determination whether the benefits accrued are likely to be continued and sustained after the end of UNICEF´s current Country Programme (2017-2019) support; and
- Gender, Equity and Human Rights is understood as the degree to which the design, implementation and monitoring of the program have taken these three important constructs into account.

3.6 Evaluation questions

The final list of evaluation questions is structured by evaluation criterion and provided below. Efforts were made to avoid applied research questions - in search for descriptive answers - and priority was given to questions that relate to merit, value and significance. Gender, equity and human rights are integrated as important cross-cutting issues, and the evaluation identified and determined how UNICEF had attempted to mainstream these into the CSD program, i.e. into the design, implementation, follow up and evaluation; specific evaluation questions were included for this purpose.

Relevance and strategic fit

1. To what extent are the current CSD program (2017-2021) objectives and outcomes relevant to the i) Government's priorities and development agenda; and ii) the SDG targets and indicators?
2. To what extent is the current CSD program (2017-2021) complementing other UN organisations and development partners in supporting the Government in reaching most vulnerable in the health sector at national, district and community levels?
3. What perceptions do the key partners and stakeholders hold of the current CSD program relevance in comparison to the 2012-2016 (with the understanding that this is subject to the stakeholders´ institutional memory)?

Effectiveness

4. What key changes are made to the design/Theory of Change of the current CSD program, compared with the former 2012-2016 CSD program and, if so, is any shift likely to enable more effectiveness in terms of reaching, and/or monitoring the reach of core outcomes?
5. To what extent did the previous CSD program (2012-2016) achieve its intended outcomes and objectives?
6. To what level does coherence and synergy exist between the current CSD and PIC Programs (in design and implementation) - to help reach the objectives and outcomes (including on the subjects of gender, equity and human rights)?
7. To what extent have the current and previous CSD program engaged NGOs in the program and helped develop their capacity to advocate for children´s health?
8. To what extent did UNICEF-supported activities during the earlier and current phase of the program ensure that the most vulnerable children and women have access to basic health services to reduce child morbidity?
9. Which are the factors (internal and external to UNICEF) that contributed the most to achievement and performance of the previous and current CSD program?
10. Which are the factors (internal and external to UNICEF) that hindered the most the success of the previous and current CSD program?

11. To what extent have unexpected outcomes (positive and negative) occurred as a result of the CSD program activities during the previous and current phase?
12. To what extent did strategic partners and partnerships contribute to the attainment of the CSD program results during the previous and current CSD program?

Efficiency

13. To what extent are financial resources, human resources and supplies (current program):
    - Sufficient in quality and quantity?
    - Deployed in a timely manner?
14. Could less/fewer resources have been used through alternative strategies with the same goals in mind - but with the same or higher level of achievements (current program)?
15. To what extent did the partnerships help keep down the costs of program delivery? To what extent did the current CSD program budget factor-in the cost of specific activities, outputs and outcomes to address the cross-cutting issues (gender, equity, human rights) mentioned below?

Impact orientation

16. To what extent has the UNICEF CSD program contributed to the reduction of childhood illnesses and child mortality, and maternal mortality?

Sustainability - and the likelihood of sustainability

17. What mechanisms (if any) were put in place for/by the Government to enable continuation of certain key CSD approaches during the previous program period (e.g. benefits, systems, knowledge, human resources, funding for supplies, drugs, vaccination campaigns)?
18. To what extent (if at all) have CSD program strategies and activities been replicated by the Government and other partners?

3.7 Methodology

In order to address each one of the evaluation questions presented in section 3.6, the evaluation was based on a participatory mixed methods approach, with a dominant qualitative methods component. As a way to fulfill the evaluation purpose and enhance the credibility of conclusion and the solidity of recommendations, the consultant made a specific effort to use multiple lines of evidence to answer all evaluation questions (triangulation).

Section 3.7.1 accounts for the selection made of the geographical areas to be visited by the evaluator, and the methods used to collect data and information. As part of the methodology, the evaluator undertook two field visits to The Gambia. The first visit was completed to (i) start the review of the programme documents; (ii) hold briefing sessions with UNICEF Staff; (iii) organize in-depth interviews and focus group discussion with key stakeholders; (iv) and make direct observations in programme sites in four of the country's regions. During the second in-country mission, the evaluator finalized the document review, conducted additional in-depth interviews (face-to-face and Skype interviews) and focus group discussions and, lastly, presented the preliminary findings in a stakeholder workshop on the mission's last day (16th May 2019).

3.7.1 Methods applied to gather quantitative and qualitative data

The evaluation used a mixed method approach to gather quantitative and qualitative data: Documentation review; Surveys for open- and close-ended questions to gather information from CSD program stakeholders; In-depth interviews and focus groups to collect information around specific themes or issues related to the evaluation; Observations to gather direct information about ongoing

program events[53] and physical environments in health facilities and other institutions and behaviours /attitudes among all stakeholders that were met. Qualitative data was collected from both primary and secondary sources, using a combination of methods listed below with the purpose to be able to capture a vast array of concepts, perceptions and opinions. Quantitative data, on the other hand, was drawn from secondary sources only - as no statistical survey was conducted as part of this evaluation. The below is a more detailed account of the methods used:

Comprehensive review of relevant documentation

- The documentary review was continuous as "new" documents, reports and surveys were made available during the second country visit. The documentation review was comprehensive and involved a great number of documents (detailed bibliography is provided in Annex V). Key documents used to extract data and information supporting the evaluation process included the following MICS data (2018), Demographic and Health Survey (DHS) Survey 2015, Nutrition Survey 2012 and Micro-Nutrient Survey 2019;
- National Development Plan; National Health Policy, National Health Strategic Plan Nutrition Policy, Reproductive, Maternal, Neonatal, Child and Adolescent Health, RMNCA, and the National Health Strategic Plan, National Nutrition Policy and the National Gender Policy.;
- The Gambia United Nations Development Assistance Framework (UNDAF 2012-2015) and the current UNDAF 2017-2021; UNICEF Country Program Documents, 2012-2016, and 2017-2021; Results and Resources frameworks; UNICEF Country Office Annual Reports (COAR), Rolling Work Plans (RWP) and preparatory planning documents; and
- UNICEF Mid-Term Evaluation of the Country Program 2012-2016 (conducted in 2014); and donor reports, technical reports; internal assessment reports, budgets, work plans and online sources e.g. Gambian online newspaper articles (e.g. from *The Point*).

Semi-structured in-depth interviews

Thirty-two semi-structured in-depth interviews were held (the approximative duration of each interview was 60 minutes) with the following groups of respondents:

- UNICEF The Gambia Country Office staff;
- MOH staff: Decision-makers, planners, program managers, program officers, administrative staff and one external consultant of MOH at national level, and MOH staff at sub-national levels including regional, district and village level);
- MOFWR; and
- NaNA, (including a former staff member), UNAIDS, UNFPA, FAO, WFP, WHO and CREN (for more details see Annex VI).

The method was selected as it allows for information to be provided face-to-face – and allows for both factual/content-related and sensitive subjects to be addressed. The topics that the interviews addressed related to perception and knowledge (e.g. about the CSD program and its intended outcomes); processes; content of the program under evaluation; achievements and impact (and lack thereof); systems; work environment; challenges; limitations; visions for the future, etc..

This method was also useful to provide information about internal arrangements, distribution of roles and tasks among staff within the respective organizations and stakeholders roles vis-à-vis UNICEF, which were identified as important factors impacting the program. It allowed for a better appreciation of various challenges faced within the respective organization, and by the individual interviewees, e.g. dysfunctional internal systems and mis-management of resources, as well as the problem of attrition within the respective organizations.

[53] E.g. an organised Village Nurse Day including check-up of new-borns, and distribution of birth certificates to the mothers.

Focus Group Discussions

16 Focus Group Discussion (FGD) were held. The selection criteria were applied. The FGDs were held with government staff, Madrassa school staff, volunteers, village leaders and community members at national, regional, district level during field visits to CRR, URR, NBE, LRR.

Table 3. Number and venues of Focus Group Discussions

Type of FGD	No of FGDs	Locations	F/M
1. Village and community level program participants & health volunteers	4	- Basse, Upper River Region; -Sara Pirasu and Kindibaru Villages and Firdawsy, Niani District, Central River Region (North Bank). -Farafenni, North Bank East -Bansang and Wassu North, Central River Region; and -Soma, Lower River Region.	12 (7 M, 5 F)
2. Coordinators, Program Managers, Deputy Programme Managers, Pharmacist Programme Officers, Health Facility Staff .	12	Banjul Municipality, Central River Region, Lower River Region, North Bank East and Upper River Region.	2 Coordinators (M) 9 Programme Managers (5 M, 4 F) 28 others (M and F check)
Total	**16**		**51**

This method was included because it allows the evaluator to float ideas, pose questions, and rather quickly get insights from different groups. The advantage of the FGDs was that the evaluator was rapidly able to understand some of the issues pertaining to the divergent participants' roles and tasks that may positively or negatively affect program implementation or follow up. For instance, they were very useful in capturing how Multi-Disciplinary Facilitation Teams actually work, what difficulties and problems they face in attempting to provide extension services (including health related) in communities and what they do to support each other. The method was also useful as it provides an insight into the dynamics of a group.

Surveys

In order to complement the information gathered during the in-depth interviews and FGDs, two online surveys, consisting of mainly open-ended questions was used and sent to selected key stakeholders (Annexes IX and X). The respondents were selected purposively and each individual received the same set of questions. E-mail containing the questionnaire were addressed to MoH, MoFWR, Ministry of Women's Affairs, Children, and Social Welfare (MoWCSW), NaNA; UNDP; FAO, WHO; UNAIDS; European Union, World Bank; The Gambian Red Cross; HePDO and National Youth Council (NYC).

A second online survey with questions tailored for UNICEF staff (CSD program staff and other Gambia Country Office relevant staff) was sent the last week of the second visit to The Gambia.

Observation

Semi-structured observations recorded through mental and visual notes were used for reality checks while visiting rural communities (the observations were a complementary technique and do not fully comply with the definitions of structured or participant observations as such). Examples are seeing the construction of the toilets in schools and Madrassas (cleanliness, hygiene units for girls, access to hand

washing facility) construction of water points and observing interaction between teachers and pupils, observing collapsed pit latrines, meeting children recovering from SAM, and their mothers, seeing women with children at visiting health centres, observing the interaction between nurses and VHWs with mothers and children, and between women and men in villages during FGDs.

Quality Assurance

The evaluation applied methodological triangulation of the responses and information received. This served the purpose of ensuring credibility and validity of the results and included cross-checking of information from different sources and obtained using varied methods.

The methods described above are believed to have been appropriate for the evaluation to acquire answers to the vast majority of evaluation questions outlined in the section 3.5 of this report including the analysis of gender, human rights and equity issues. Attention was paid to ensure data quality, including evidence supporting the reliability and validity of data collection tools. The evaluator took hand written notes that were transferred to her computer file via voice-recorder. Preparations were done prior to interviews and FGDs. All official staff spoke English. For community members and Madrasa staff who did not speak English, an English-speaking assistant was called in to help in the translation. The consultant is fully aware that some information was lost in translation, but because different languages are spoken in different parts of the country, it was perceived not to be practical to have an interpreter coming along (and the cost of having interpreters had also not been factored into the budget for the evaluation).

3.7.2 Some limitations to the methods used

Three main limitations were identified and so were the strategies put in place to mitigate them.

- Regarding the limitations of purposive sampling as regards the field visits, there is a relatively high risk of bias. This was *mitigated* by collecting and analysing information from many sources (triangulation);
- Regarding the FGDs, the role of the facilitator is to provide a safe space for every participant to provide her/his opinion. However, there could be a situation where some participants are not expressing their voice, perhaps due to the presence of an authority or otherwise influential person. *In this situation*, the interviewer approached some participants individually after the FGD had ended, keeping in mind that the information would have to be kept confidential; and
- Regarding in-depth interviews a limitation is that they may be subjective, also mitigated by triangulation.[54]

For other limitations to this evaluation (not method-related), please see section 3.9.

3.7.3 Sampling strategy and methods

Data was collected from a variety of stakeholders, both in and out of the country's capital, Banjul. The sampling frame agreed upon with UNICEF included the most socio-economically deprived areas of the country where the CSD program concentrated its activities: CRR, URR, LRR and North Bank Region. Purposive sampling was used to select sites in each one of the three regions for data collection purposes. The Ministry of Health and its Regional Health Centres (secondary level health facilities) were first contacted by CSD staff, according to UNICEF practice to meeting with directors of government-run health centres before organising field visits. The Directors of the respective centers and their staff participated in Key Informant Interviews (KII) and FGDs. The following sampling criteria for site selection were agreed upon with the CSD Manager, Program Officers and the Programme Monitoring and Evaluation (PM&E) Specialist, who also assisted in selecting the sites for visits. The selection criteria included:

[54] These limitations mentioned here are also mentioned in the Inception Report to this Evaluation.

- Health centres, and villages that are located in the socio-economically most deprived regions (and those that CSD has focused on in the current and previous program) – thus bringing out the range of relevant health and development issues;
- Health centres and nutrition rehabilitation centres that perform well, less well and poorly;
- Centres and villages in remote locations where the consultant could have FGDs with numerous stakeholders, including community members (women, children and men); Village Development Committees (VDC); Village Support Groups (VSG); Multi-Disciplinary Facilitation Teams (MDFTs); and health volunteers e.g. Village Health Workers (VHW) and Community Birth Companions (CBCs); and
- Selection was to be made of primary schools and madrasas in remote areas.

Applying the above listed criteria and with the support of Gambia CO staff, the RHCs in the CRR, URR and LRR were selected. The consultant proposed to carry out the field visits on her own without the company of any Programme Officer, however, as the CO advised against this for security reasons, she was accompanied by the UNICEF PM&E Officer – who did not participate in the majority of FGDs and interviews as not to risk influencing the response in the FGDs an interviews.

Table 4. Evaluation Sample (by method)

Data collection method	Sampling strategy and criteria	Number of persons sampled
Semi-structured in-depth interviews	The informants were purposively selected. The consultant had an initial list of sites, institutions and key informants resulting from early documentation review. During the visit to The Gambia, the PM&E Officer and key management staff supported the consultant in elaborating and exhaustive list of all relevant stakeholders who could provide valuable information on the program.	40 persons were envisaged to participate in the interviews; eventually it was possible to hold **32 in-depth interviews.**
FGDs	The participants for the FGDs in the rural areas were selected purposively. The inclusion criteria for the participants were: government staff, community or volunteers. Due to the high staff turnover it was found not feasible and other practical considerations to select participants based on name lists but participants were recruited from persons holding the relevant positions.	It was planned that 30 persons would participate in 10 FGDs; eventually **51 persons** attended 16 FGDs.
UNICEF staff survey (questionnaire attached as Annex IX)	The intended respondents were selected purposively from the list of UNICEF Gambia staff drafted for the purpose of the in-depth interviews and completed by persons who did not previously participate to the interviews. The inclusion criteria were: being a CSD program staff or holding a key position within the UNICEF Gambia office.	The questionnaire was sent to 20 persons **with 4 persons** responding (20 per cent rate)
Partner and Stakeholder survey (questionnaire	The intended respondents were selected purposively among the personnel of the following organizations: MoH, MoFWR, UNAIDS, NaNA, FAO, WHO, WFP,	The questionnaire was sent to approximately 20 persons with **4 persons responding**

Data collection method	Sampling strategy and criteria	Number of persons sampled
attached as Annex X)	UNAIDS, World Bank, Ministry of Women Affairs, The Gambian Red Cross, HePDO.	(15 per cent response rate).

3.7.4 Approach to Stakeholder participation

This evaluation was expected to bring out and promote accountability and learning and enable UNICEF CSD and its partners to appreciate how – and to what extent – intended and unintended results were achieved. The evaluation approach was participatory in the sense that all who took part were encouraged to share information and knowledge. Accountability was ensured through presenting the preliminary findings in a Stakeholder Workshop in the UN Conference Room on 16th May 2019 (Annex III). Through the Question and Answer session and open discussion that followed the thirty-three attendants all had an opportunity (and were encouraged to) provide feedback to the presentation.

3.7.5 Data analysis

Qualitative data analysis was carried out through a deductive approach that informed the evaluation findings and conclusions. Thus, the gathered qualitative data from the interviews and FGDs was subject to thematic content analysis. Data was coded, classified and interpreted to identify patterns and links with the evaluation´s objectives and in relation to the evaluation criteria and evaluation questions. The steps taken in the analytical process to arrive at conclusions involved transcription, organization and validation of the data. Quantitative data was drawn from secondary sources as explained above.

3.8 Evaluation norms, standards and ethical considerations

The evaluation adhered to UN standards and norms as spelled out in various United Nations Evaluation Group (UNEG)[55], UNICEF evaluation guidance documents and the standards of the Global Evaluation Reports Oversight System (GEROS)[56]. The evaluator has been mindful of ethical standards in the collection and analysis of data. For instance, care was taken not to let conclusions in the evaluation process be influenced by the views or statements of any party but ensure impartiality and independence as part of the quality assurance process. The evaluator was also mindful of ethical standards and code of conduct as spelled out in the UNEG ethical guidelines for evaluations and specifically, in protecting those involved in the evaluation process. Thus, names of interviewees are not linked to their answers, and names of community members who participated in focused discussions are not mentioned in the report. All key informants and respondents who participated were informed about the purpose of the CSD evaluation and asked if they were willing to answer questions were treated with respect.

To ensure independence and avoiding any conflict of interest the evaluator insisted more than once that the work process of the evaluator must be independent – for instance during field visits, designing Survey questions and ensuring that the survey respondents send their replies only to the evaluator. The evaluator has kept in mind and utilised every opportunity for triangulation and cross-checking – not taking information received for granted to enhance the credibility of the process. Thus, information generated in interviews in the program was cross-checked during field visits and visits to the government office.

3.9 Limitations of the evaluation (beyond the methods)

The evaluation methodology rested on an extensive primary data collection in the field as documentary review. Therefore, availability of informants and relevant documents in time was key for the success of the process. The key challenges affecting the evaluation were late access and availability of relevant documentation, including performance measurement information to determine progress in reaching

[55] https://www.betterevaluation.org/en/resources/example/UNEG-evaluation-standards-2016
[56] https://www.unicef.org/evaluation/index_GEROS.html

outcomes which was either very limited or absent in the documentation provided the evaluator. Another key challenge was the late and outdrawn process of making appointments with stakeholders outside of the UNICEF Country Office. In addition, the fact the changes were made to the ToR included in the consultancy advertisement caused initial confusion e.g. the evaluator was requested to cover the earlier phase of the program as well, which had started in 2012 - thus the scope of evaluation became a six-years period, which was not clarified at the onset. The other methodological limitations and mitigation strategies applied by the consultant are presented in Table 4 below.

Table 5. Limitations of the evaluation and management and mitigation measures

Limitation	Management and mitigation measures
Late access to documents – some crucial documents were made available long after the data gathering process had started and some were not accessed until the second country visit. A few documents were not provided to the consultant despite several requests, including PIC evaluation report, program expenditure estimate data, and results-based monitoring data to use against targets and indicators.[57]	The search for relevant documentation was continuous and took place throughout the entire evaluation process.
Lack of robust and recent quantitative data on access to, and demand, for health care, immunisation and prevalence of diseases by differently abled children and/or mothers, or children living outside family care or in conflict with the law.	The evaluator relied on information provided in interviews and focus group discussions.
Very low response rate to the Stakeholder and UNICEF staff survey towards the end of the second field visit - which meant that a number of questions were left unanswered even after the completion of 2 field visits.	Reminders were sent by e-mail.
CSD lacks a Logical Framework Analysis (LFA) Matrix and a comprehensive Theory of Change (ToC) Matrix.[58]	The evaluator constructed a *basic* LFA Matrix based on the UNICEF Programme Document 2017-2021 (CSD Section), the current RWP the result-based strategic planning elements in the CSD program documentation (Annex XV).[59]

[58] A "skeleton" ToC text is inserted in section 2.1.
[59] See section 2.1 for more explanation of the logic developed by CSD program (a TOC skeleton: "If – Then" logic).

4 EVALUATION FINDINGS AND PRELIMNARY CONCLUSIONS

This chapter includes the findings and preliminary conclusions of the evaluation, by the five evaluation criteria relevance, effectiveness, efficiency, impact and sustainability.

4.1 Relevance

1. To what extent are the current CSD program objectives and outcomes relevant to the i) Government's priorities and development agenda; and ii) the SDG targets and indicators?
2. To what extent is the current CSD program (2017-2021) complementing other UN organisations and development partners in supporting the Government in reaching the most vulnerable in the health sector at national, district and community levels?
3. What perceptions do the key partners and stakeholders hold of the current CSD program relevance in comparison to the 2012-2016 (with the understanding that this is subject to the stakeholders´ institutional memory)?

1. To what extent are the current CSD program objectives and outcomes relevant to the a) Government's priorities and development agenda; and b) the SDG targets and indicators?

1.The CSD program is aligned with the National Development Plan (NDP) (2018-2021) which was drawn after 2016 elections in The Gambia. It contributes to the United Nations Development Assistance Framework (UNDAF) for the period 2017-2021. UNDAF is designed to guide the UN agencies in its contributions to the Sustainable Development Goals (SDGs) - in particular the health-related SDG 3; the nutrition-related SDG 2; and the water and sanitation-related SDG 6. UNDAF has three key priorities areas (1) Governance, Economic Management and Human Rights; (2) Human Capital Development; and (3) Sustainable Agriculture. UNICEF is leading the second priority area which includes education, health, social protection and gender and youth. The CSD program is geared to improve health of children under 5 years and their mothers/care-givers within these areas under Human Capital Development section of UNDAF:

- Increased equitable access to quality health care for all (2.2);
- Increased access to equitable water, sanitation and hygiene for all (2.3); and
- Increased equitable and quality access to nutrition-specific and -sensitive services (2.4).

2.UNICEF has provided technical support within the CSD relevant themes, to the Government´s policy development at national level[60]. It also contributed to the new NDP 2017-2021 (technical know-how) and UNDAF. Table 5 presents the key policies that UNICEF-CSD has contributed to since 2012:

Table 6. UNICEF-CSD´s contributions at policy level 2012-2021

Policy level activities 2012-2016		Policy level activities 2017-2021	
Health	Health Sector Bottleneck Analysis in 2014, and an Investment plan	Health	Reproductive, Maternal, Neonatal, Child and Adolescent Health (RCMNCAH) Policy (2017-2026); and Strategic Plan (2017-2022 National Health policy (2017-2026)

[60] Sources: In-depth interviews with key informants, focus discussions and document review.

Policy level activities 2012-2016		Policy level activities 2017-2021	
	Prevention of Mother to Child Transmission (HIV) Bottleneck Analysis		Strategic Plan for the Reproductive Maternal New born Child and Adolescent Health (2017-2022)
	A Policy and Strategic Plan to reduce Malaria 2014-2020		Roadmap for Revitalizing and Scaling-up of Primary Health Care.
Nutrition	Integrated Management of Acute Malnutrition (IMAM)	Nutrition	Nutrition Bottleneck Analysis in 2017[61]
	Preparations for the Nutrition Bottleneck Analysis, and a SMART Nutrition survey.		National Nutrition Policy and the new Nutrition strategy
WaSH	A Sanitation Bottleneck Analysis in 2014	WaSH	Wash Bottleneck Analysis in 2017
	Ministers´ commitment in 2016 to eliminate OD which was perceived as a milestone.		WASH Action Plan and 2017 Annual Work Plans – following the ministerial commitment.[62]
	National Sanitation Policy (to be effective in 2017) adopted by the Cabinet in February 2016[63]		National ODF Action Plan, 2017

3.The changes in government delayed the development of the NDP 2017-2021, in respect to the national health policies, as many government officers were new. The major government change required UNICEF staff to spend more time in discussions with their newly appointed governmental counter-parts and required time to become familiar with the new government's policy and administrative approaches – all which delayed implementation. [64]

Preliminary Conclusion

REL 1. The CSD program is relevant as it contribute to the new Government´s national development priorities and development agenda. It is also in line with international

[61] UNICEF Gambia extended technical support to conduct both the Nutrition and WASH bottleneck analysis. Source: COAR 2016. The recommendations from the Nutrition Bottleneck Analysis (BNA) were key in reviewing and updating the 2010-2020 National Nutrition Policy and in developing the new nutrition strategy to address key supply, demand and quality related bottlenecks at national and regional levels. The recommendations from the WASH BNA resulted in the development of an action plan for the removal of the priority bottlenecks. Source: COAR 2016.

[62] UNICEF has also advocated for this national plan which is intended to enable reaching "underserved populations" Source: UNICEF COAR 2016.

[63] Through UNICEF advocacy, this policy was adopted and approved by the Cabinet in February 2016 (it was delayed by several years). Source: COAR 2016.

[64] UNICEF staff informed that the previous Government´s Vision 2020 Document should no longer be regarded as a document guiding the country, as it was drawn by the previous government.

development priority areas – the SDG and targets through making inputs to, and aligning to the UNDAF (Par 1-3)

2. To what extent is the current CSD program (2017-2021) complementing other UN organisations and development partners in supporting the Government in reaching the most vulnerable in the health sector at national, district and community levels?

4. In respect of the other UN agencies present in the country, UNICEF has assumed a specific role to build the capacities of the Government in the health sector, addressing and advocating for vulnerable groups in society, namely maternal and child health for children under five years of age, in a combination with addressing nutrition and WaSH. Because of its access to all levels of the three-tier health care system, it is able to support the MoH in its attempts to improve on its provision of services to village and community levels. In respect to immunisation, UNICEF The Gambia has the sole responsibility among the UN organisations to implement regular and country-wide immunisation campaigns to meet the needs of children under 5 and their mothers - funded through GAVI in its role as Grant Manager for these funds.

Preliminary Conclusion

REL 2. CSD is found to be relevant, as it has a unique role in caring for children under five years - and supplements the Government´s and other stakeholders´ efforts in enhancing child health, survival and development, and improving maternal health in vulnerable rural regions in the country. (Par 4)

3.What perceptions do the key partners and stakeholders hold of the current CSD program relevance in comparison to the 2012-2016 (with the understanding that this is subject to the stakeholders´ institutional memory)?

5.Perhaps as a result of the high staff turnover (attrition) within MoH in particular, but also within other national institutions and UN agencies in the country, not many respondents and interviewees were able to recall any particular difference between the current and former CSD program. A few exceptions are some who estimated that the current program is more relevant as it is able to provide services to village and community levels as a result of the focus on the VDCs as entry points for PHC services to the rural areas.

Preliminary Conclusion

REL 3. The majority of the key partners and current stakeholders have given credit to UNICEF-CSD and emphasised the importance and relevance of its long standing presence in the country but that due to lack of evidence it is not possible to make a comparative judgement regarding the earlier 2012-2016 program (Par 5)

4.2 Effectiveness

4. What key changes are made to the design/Theory of Change of the current CSD program, compared with the former 2012-2016 CSD program and, if so, is any shift likely to enable more effectiveness in terms of reaching, and/or monitoring the reach of core outcomes?
5. To what extent did the previous CSD program (2012-2016) achieve its intended outcomes and objectives?
6. To what level does coherence and synergy exist between the current CSD and PIC programs (in design and implementation) - to help reach the objectives and outcomes (including on the subjects of gender, equity and human rights)?

7. To what extent have the current and previous CSD program engaged NGOs in the program and helped develop their capacity to advocate for children´s health?
8. To what extent did UNICEF-CSD supported activities during the earlier and current phase of the program ensure that the most vulnerable children and women have access to basic health services to reduce child morbidity?
9. Which are the factors (internal and external to UNICEF) that contributed the most to achievement and performance of the previous and current CSD program?
10. Which are the factors (internal and external to UNICEF) that hindered the most the success of the previous and current CSD program?
11. To what extent have unexpected outcomes (positive and negative) occurred as a result of the CSD program activities during the previous and current phase?
12. To what extent did strategic partners and partnerships contribute to the attainment of the CSD program results during the previous and current CSD program?

4.What key changes are made to the design/Theory of Change of the current CSD program, compared with the former 2012-2016 CSD program and, if so, is any shift likely to enable more effectiveness in terms of reaching, and/or monitoring the reach of core outcomes?

6. The documentary review of the two UNICEF´s Country Programme documents attested that the formulation of the current CSD program is more subject-specific in comparison with the previous one. Health, Nutrition and WaSH have been made to constitute separate outcomes. The old program had only two result areas in which the first had lumped together health, PMTCT, nutrition and WaSH in one single outcome - while the second outcome was adoption of essential care practices. Some new concepts were added in the new program design, such as the terms "equity" and "behaviour change" which were linked to the health outcome; "rights" issues being linked to the nutrition outcome, and "utilization" being linked to the WaSH outcome. The term "utilization" has also been linked to resources while in the earlier program, only "**access**" to resources was mentioned. Some UNICEF staff members have pointed to the fact that the new country UNICEF Program allows for improved integration between the program components compared with the previous one; and that the Annual Management Plan had been helpful in giving clear priorities, believed to enhance effectiveness of implementation in the remaining period.

7. While the earlier CSD program focused on 20 districts in CRR, URR and NBE – the new program is now national in scope, however, CSD Manager and staff members explained that, notwithstanding, *CSD could still give more attention to some areas more than others where the highest impact can be generated*, including in urban areas. It was informed that activities had started in order to provide more targeted services in the Western Coast Region to, for instance, making sure that the households/families do not refrain from utilizing the immunization services because of an unfavourable environment e.g. too crowded health facilities which reportedly had been the case in some urban areas.

Preliminary Conclusion

EFFEC 1. The new CSD program design has allowed for a more specific focus on health, nutrition and WaSH, as each now has constituted a separate outcome with its own set of outputs and activities. It has added the terms "equity" and "behaviour change" linked to the health outcome; "rights" issues to the nutrition outcome, and "utilization" to the WaSH outcome., indicating that these aspects are important to monitor in the implementation. The program´s geographical areas are no longer confined to a few regions but can give attention to some areas where it is found that there are great needs for support. (Par 6,7)

5. To what extent did the previous CSD program (2012-2016) achieve its intended outcomes and objectives?

8. In 2014 UNICEF commissioned an In-Depth Review (hereafter referred to simply as IDR 2014[65]) of the Country Program Action Plan (CPAP). The purpose was to review the progress made between 2012-2014 and to analyse the strategies and principles used to achieve the key results. The report did not specifically refer to what progress was made against the intended results (PCR and IR) at mid-term. However, it states that the YCSD program was in the process of achieving the intermediate results by 2016 – thus, oddly, it predicted results that *were to be achieved two years after the* review had taken place: Revitalization of the PHC strategy; Universal coverage for children under 5 years for immunizations; High impact health and nutrition interventions; WaSH services in 200 Program for Improved Quality Standards in Schools (PIQSS) schools; and disaster risk reduction strategies and supplies, and diseases prevention and treatment interventions to all children affected by disaster. Regarding effectiveness in the reaching the actual outputs/outcomes of the YCSD program ending 2016, the evaluator has not had **access** to data which shows results indicating effectiveness vis-à-vis producing the actual outputs in order to determine the reach of the outcomes.[66]

9. A number of specific activities were mentioned in the IDR 2014: In the area of providing primary **health care** and promote household behaviours, a result of the YCSD activities by 2014 was that 75 per cent of care givers in the 20 targeted districts would have functional knowledge and skills in what is called "4+2 key household behaviours". These are behaviours promoted by UNICEF to counteract the most serious threats to the survival of children under 5 (in 2017 it was expanded to 4+4 behaviours), i.e. two more essential behaviours were added to this concept.[67] The key messages delivered in communities should lead to essential care including early antenatal registration and newborn care to prevent sepsis, promote cord care and uptake of colostrum through breastfeeding. The roles of the Village Health Workers (VHWs) and the Community Health Nurses (CHN) were viewed as important in spreading the messages.

10. The accomplishments mentioned in the report include an investment plan for the sector based on a bottleneck analysis to guide implementation and resource mobilization. In the area of **health** it is mentioned that a total of 228 PHC villages had been reached with UNICEF-supported health services including provision of medicines and other supplies benefitting 4,762 children particularly in URR and CRR – which were the regions that UNICEF supported during this period. Compared to countries in the sub-region, the country had maintained high immunization coverage rates for Polio, Measles and TT2. Both in 2012 and in 2013, the rate was reported to be 96 per cent and new vaccines have been introduced each year.

11. In the area of **nutrition**, UNICEF had supported NaNA to carry out a national Nutrition Survey using a SMART methodology in 2012. The results showed high malnutrition rates: 21.2 per cent of children under five stunted; 9.9 per cent were wasted and 1.6 per cent were found severely malnourished. In 2013 the GDHS found that the situation had worsened with 24.5 per cent under five being stunted, 11.5 per cent wasted and 3.9 per cent severely malnourished. These survey results enabled data generation, contributing to evidence-based planning, progress assessment and advocacy. The work to prevent malnutrition among children under five included the promotion of optimal Infant and Young Child Feeding Practices (IYCF), complementary feeding, strengthening the treatment of severe malnutrition using the Integrated Management of Acute Malnutrition (IMAM) approach.[68] The IMAM protocol was reviewed in 20 targeted districts. The UNICEF-CSD also contributed to the Nutrition Bottleneck analysis. Furthermore, it is mentioned the YCSD enhanced the skills through capacity development activities of 182 Health Workers and 200 community health workers and

[65] NB: The report does not clearly have date, but the review covered 2012-2014 but it is likely that it was finalised in 2014, or possibly 2015.
[66] The use of MICS 2010 and MICS 2018 suggested by UNICEF as proxy, is quite unreliable in determining YCSD program results as there is a 3 years difference (the former Program was implemented 2012-2016).
[67] This approach originally comes from WHO and the Child Health Epidemiology Reference Group (CHERG) in 2014.
[68] RAM report, UNICEF Country Office, 2015

supervisory visits. At the time of the review, approximately 61 per cent of the acute malnutrition cases among children under 5 had been effectively treated.[69]

12. In the area of **WaSH,** services were delivered, utilized and maintained in schools and reportedly, a total of 20,685 pupils (46 per cent) of the 200 targeted schools had acquired **access** to functional improved water and sanitation facilities as a result of the program interventions for Improved Quality Standards in Schools (PIQSS) in the 20 targeted districts. Monitoring was done on effects of the (2009) training on the Community Total-Led Sanitation (CLTS) approach that had targeted communities in West Coast Regions, particularly along the Gambia – Casamance Border, Central River, Upper River, and Lower River Regions further reducing OD. The program also implemented WaSH activities in border areas and in relation to Ebola prevention and delivered messages/training on household practices. Village Support Groups (VSG) with 2600 members were recorded to have had increased knowledge as a result of UNICEF´s activities e.g. promoting key household behaviours for improved child care. The achievements included UNICEF´s involvement in ending Open Defecation (OD) practices.[70]A predicted result was that by 2016, 600 communities would be committed to OD and have implemented a CLTS action plan[71]. There is no data available indicating how many were committed by 2016, but it was informed to have been *only partially* achieved. It is acknowledged that some areas do have problems e.g. in CRR North where communities still practice OD, although nationally it has decreased considerably during the last 5-6 years (estimated at 1 per cent).[72]

13. To be noted: The evaluator has searched for reliable documentation that would enable an evaluation or assessment on the extent to that the CSD had produced the outputs and/or attained the PCRs at the end of the former program cycle in 2016. In the absence of external evaluation reports the evaluator requested the Country Office to share any internal reviews and monitoring data in order to appreciate what achievements had been recorded that could be compared against targets. Two internal Mid-Year Reviews of the RWPs were made available (power points only) for previous program; one for 2012-2013 and one for 2014-2015. The first one has very scanty information and is incomplete; while the latter is an empty format – **thus this has not helped the evaluator to assess or determine *the extent* to which the envisaged outputs and outcomes were fulfilled and the evaluation has thus had to rely on available documentation, and interviews.**

14. This situation has not provided an opportunity to safely measure, or determine, how the UNICEF YCSD had achieved. The Country Office Annual Report (COAR) for 2017, mentions that the CSD during the previous program period had suffered set-backs in terms of finding suitable experts to work on the Integrated Monitoring and Evaluation Plan (IMEP) which was intended to fill the knowledge gap which was needed in order to develop the new (current) Country Programme. It stated that activities were either delayed or postponed due to unavailability of consultants, timing constraints and limited funding. This constraint may explain some of the challenges faced by the present evaluation in 2019 in identifying data that may be compared to targets and indicators (for more details on YCSD activities and achievements, see Annex XI).

Preliminary Conclusion

EFFEC 2. Regarding effectiveness in reaching the actual outputs/outcomes of the YCSD program ending 2016, the evaluation has not had access to reports *that shows results against targets at the end of the program cycle* that could inform about the rate of effectiveness vis-à-vis producing the actual outputs/outcomes. The In-depth Review in 2014, however, concluded that the program supported the Government in providing primary health care, vaccinating children against infectious diseases, promoting household behaviours and revitalizing the PHC strategy. Surveys were carried

[69] Source: The IMAM database is referred to as a source.
[70] Source: IDR, 2014.
[71] This is Output 2.2. Source: PPT 2016 End-Year Review of 2015-2016 Rolling Work Plan Child Survival and Development.
[72] Source: The evaluator triangulated this issue with many of the stakeholders including the former WaSH specialist who left the program in 2018.

out in the area of nutrition that, reportedly led to evidence based planning, assessment and policy advocacy. Through raising capacity of health workers among others, supervision, work on delivery of improved water and sanitation facilities the program has contributed quite effectively to the government´s efforts in improve on child survival and development (Par 8-14)

6. To what level does coherence and synergy exist between the current CSD and PIC programs (in design and implementation) - to help reach the objectives and outcomes (including on the subjects of gender, equity and human rights)?

15. The CSD Program Document outlines areas where the CSD and PIC were meant to work closely together (synergy) such as with the inclusive education component on making community services accessible to children with disabilities, and in emergencies prepare for response and build resilience. Further, CSD would take part, with PIC, in an activity addressing information communication technology (ICT) using geographic information system (GIS) mapping to generate real-time data on community services. Apart from cooperation on emergency response, none of the above has taken place.

16. Synergy in program delivery is found to some extent: in the social protection activities (cash transfer to mothers with newborns), birth registration and providing birth certificates to mothers[73], constructing separate toilets for adolescent girls in schools ensuring their rights to an education and prevent early marriage and clean water in schools.[74] However, it was found that an organisational "silo" exists within the Country Office constituting a hindrance to full synergy between the different sections, including PIC and CSD. This has resulted in a tendency of some staff members to focus on a few single outcomes and outputs – and not taking into consideration the bigger picture and the organisational objectives. Staff members in one program are oftentimes not aware of what colleagues in another program are working on. The new management is well aware of these organisational boundaries and the necessity for improved integration was brought up by several staff members in the interviews. While some staff members have perceived that the program structure is clear (well-defined outcomes and outputs), others have commented to the evaluator that the structure limits the integration of tasks and responsibilities allowing for little room to adjust activities in creating more coherence. The idea of "enforcing" integration as an alternative for program management was even mentioned.[75]

17. Two staff members in the Country Office have Communication for Development (C4D) as part of their functions in the new overall UNICEF programme (cross-cutting functions). The aim was to enable the generation of outputs on behavioural change, demand creation and utilisation of services. Some staff members have expressed that the introduction of the cross-cutting functions have helped individual staff to work better together across programs.

Preliminary Conclusion

EFFEC 3. Synergy of CSD and PIC programs has been found to some extent at both national and sub-national level in social protection activities (cash transfer to mothers with newborns), promoting birth registration and birth certificates to mothers, constructing separate toilets and clean water for adolescent girls in schools ensuring their rights to an education and prevent early marriage. The organisational silo in the country office has been somewhat dealt with (mitigated) by the fact that new staff´s responsibilities include cross-cutting issues that concern both programs, such as C4D, behaviour change, gender issues. The management has expressed willingness to address this issue for increased effectiveness in reaching outcomes. (Par 15-17)

[73] Source: UNICEF staff interviews and staff survey. Birth certificates have been provided to 52 per cent of children under 5. This is an area that UNICEF has supported for many years in The Gambia with the development of the first National Birth Registration Strategic Plan of the MoH for 2013-2017.
[74] Source: IDR 2014.
[75] Sources: Staff survey and interviews with UNICEF staff including management.

7. To what extent have the current and previous CSD program engaged NGOs in the program and helped develop their capacity to advocate for children´s health?

18. It was found that the involvement of Non-Governmental Organisations (NGOs), Civil Society Organisations (CSOs) and/or and "champions" for child survival from the private sector or civil society has been scarce both in the current and previous program.

19. In 2016, an internal UNICEF review document recommended that the program should explore the possibility to engage NGOs in implementation of activities, i.e. Child Fund and the Gambian Red Cross Society (GRCS). According to CSD current and former staff, efforts have been to engage NGOs in the work at community levels.[76] It was found that HePDO[77] and the GRCS indeed have been involved in times of emergencies and disaster prevention in the previous program (2016 emergency situation caused by flooding) and that in the current program staff members are planning to involve HePDO more in the WaSH areas including CLTS during 2019. However, no strategy has been identified on how CSD could *develop capacity of potentially relevant organisations to advocate for children´s health*.

Preliminary Conclusion

EFFEC 4. The involvement of NGO, CSOs and individual "champions" in the sector has been scarce and *mainly* occurred during emergencies, involving the GRCS and HePDO. The CSD program has no strategy on how to involve them more, or raise their capacity to help advocate for children´s health and survival. (Par 18-19)

8. To what extent did UNICEF-CSD supported activities during the earlier and current phase of the program ensure that the most vulnerable children and women have access to basic health services to reduce child morbidity?

20. The Situational Analysis (SiTAN 2015) commissioned by UNICEF (December 2015) found that access to health services had improved significantly, particularly in urban regions – but there was less clarity regarding demand for services. In the absence of quantitative data on results against the targets[78] and access to services by the most vulnerable children and women in the selected program areas – the evaluation has had to rely on information from documents such as the SiTAN, interviews and FGDs in the field.

21. Apart from the vaccination campaigns which has a nation-wide scope, the CSD has focused on the most vulnerable regions in the country. It has trained and sensitised the various categories of health staff, VHWs, VDCs, and to some extent volunteers, on the concept of Primary Health Care and essential care (including early antenatal registration and newborn care to prevent sepsis, promote cord care and uptake of colostrum through breastfeeding). However, as also reported here, there are within these regions areas where children and mothers are more vulnerable than others, and where socio-economic indicators are worse than in the more centrally located areas - and where problems with malnourished children for instance may be greater. These are communities that live far away from the public health facilities, including the Non-PHC communities. In efforts to try to make a difference also in these areas, Village Nurses, who are part of the Multi-Disciplinary Facilitation Teams (MDFT), and VHWs, make visits to these villages to offer services that are part of the CSD efforts focusing on MCH and child survival. However, FGDs with MDFT teams revealed that Nurses have been assigned a vast number of remote communities to be visited and were not able to visit each and every village even once in a year.

[76] Sources: In-depth interviews.

[77] HePDO is a local NGO that has conducted hygiene promotion and CLTS training of Lumo (traditional trading) committees, in schools and madrasas. With the help of this NGO, solutions will be sought in the riverine areas among the most vulnerable communities facing problems to build toilets due to high water levels.

[78] As for the current CSD program, a results framework elaborated in 2017, has specific indicators and *baseline* values (2013, and 2015) as well as *targets* (in percentage), but not *results* and no such document was received for 2018.

22. Apart from the vaccination campaigns which has a nation-wide scope, the CSD program has focused on the most vulnerable regions in the country. It has trained and sensitised the various categories of health staff, VHWs VDCs (and to some extent volunteers) on the concept of Primary Health Care and essential care (including early antenatal registration and newborn care to prevent sepsis, promote cord care and uptake of colostrum through breastfeeding). However, as also reported here, there are within these regions areas where children and mothers are more vulnerable than others, and where socio-economic indicators are worse than in the more centrally located areas - and where problems with malnourished children for instance may be greater. These are communities that live far away from the public health facilities, including the Non-PHC communities. In efforts to try to make a difference also in these areas, Village Nurses, who are part of the Multi-Disciplinary Facilitation Teams (MDFT), and VHWs, make visits to these villages to offer MCH-oriented services. However, the FGDs revealed that Nurses had a vast number of remote communities that were to be visited, and that, in fact, they were not able to visit each and every village even once - due to their remoteness, and also because (in the case of female nurses) they do not feel comfortable to travel long distances. Sometimes they team up with another MDFT (male) official. Some women who participated in the FGDs, however, expressed that the Village Nurse and VHWs are important contacts and they appreciate their advice and how to care for themselves and their newborns, the birth registrations and check-ups on their newborns (screening for malnutrition), as well as the vaccinations. Some women in the more remote areas mentioned a number of difficulties in accessing health services, and in one village the women said that no health staff had visited their villages. The key obstacle faced by women in giving birth at health facilities was the long distances and the bad roads. Some women stated that if an emergency situation occurred someone who has a car would be called for to take the woman to the health facility or hospital. Others said that women are reluctant to visit health facilities when giving birth as some women who had complications had lost their lives when taken there on the donkey carts. Community Birth Companions (formerly Traditional Birth Attendants) who took part in FGDs confirmed that they had a role to encourage women to give birth in health facilities, but said that the women sometimes prefer not to go. Even when women do make it to the health centre (access), facilities are not always suitable for child birth – there may be lack of equipment during emergencies, or the women do not feel comfortable due to some environmental factors.[79] There is no indication or evidence that CSD has any strategy to ensure access of services to children or mothers who are differently abled.

Preliminary Conclusion

EFFEC 5. CSD has trained and sensitised the various categories of health staff, VHWs VDCs (and to some extent volunteers) in the most vulnerable regions on the concept of Primary Health Care and essential care (including early antenatal registration and newborn care to prevent sepsis, promote cord care and uptake of colostrum through breastfeeding).To some extent efforts have been made to reach the **Non-PHC** villages to spread messages and create demand to visit health facilities but the logistical problems have limited these. No evidence has been detected of any particular efforts to provide service to, or create demand from, differently abled children, who are among the most vulnerable children. (Par 20-22)

9. Which are the factors (internal and external to UNICEF) that contributed the most to achievement and performance of the previous and current CSD program?

23. Despite the absence of solid information at hand regarding the achievement of the former program objectives– and the fact that the current program is implemented only half way, certain factors nevertheless stand out. An internal factor is that at the beginning of the previous program UNICEF staff realized that much effort had been made to work on water and sanitation issues on a *project*-basis – and it was therefore necessary that the Government would *adopt the issue* and allocate resources for it.

[79] In one Health Centre the room for giving birth was adjacent to the room where children had been brought together with their mothers, which clearly was inappropriate and making both women and children uncomfortable.

Through UNICEF-CSD´s dedicated efforts, Open Defection (OD) issues were finally fully acknowledged at the end of the previous program cycle and is now an inter-ministerial issue.

24. Another contributory factor to achievement in this area is that young people were engaged in the work to advocate for ODF communities in the rural areas, through the National Youth Council. Although it is estimated that one percent of the households still practice OD[80], these actions seem to have contributed to more awareness among the public and the stakeholders. In addition, the new Government has declared that maternal and child health is a priority.[81]

25. A few external factors also stand out, as follows:

- The new government with the new development agenda (expressed in the NDP and national health sector strategy developed after the new government was installed) – is supportive to UNICEF´s programs, for instance: In showing interest in quality support provided to the ministry from UNICEF and CSD program. An example of this is that the new Permanent Secretary, MoH, participated in the Validation workshop in which the evaluation´s preliminary findings were presented and stated that the Government is concerned about UNICEF-CSD´s many capacity building activities involving the ministry staff – and is keen to know the results generated from the training of staff under the program. This was interpreted by UNICEF staff as a good sign that the new Government is more interested in accountability and in real changes and impact in the area of child survival and related issues in the health sector;
- Another important factor is the *Nsaa Kenno* approach, launched by the First Lady and supported by UNICEF that has helped the staff to appreciate and work with cross-cutting issues; and
- The VDC is the agreed entry point to the PHC – which gives much more room for increased delivery of quality health related services and messages to the most vulnerable communities.

26. Internally there are contributory factors to progress, such as the fact that he number of staff and the budget of UNICEF has doubled which should generate more quality results in the quest for child survival also. The strong partnership and mutual understanding between UNICEF-CSD and WFP is important. The new Country Representative´s determination to encourage more ownership within the Government and networking skills also stand out as being able to contribute to the achievement of both CSD and PIC programs (for more details on CSD activities and achievements, see Annex XI).

Preliminary Conclusion

EFFEC 6. In the previous program, CSD´s dedicated work and advocacy in highlighting and working to create ODF areas, through using radical approaches such as the CLTS, prompted the Government´s to officially acknowledge that ODF schools and institutions are inter-ministerial issues and that the practice of "open defecation" impacts negatively on child health. Although there are still remaining pockets of OD, the work is no longer on a project basis but part of the Government´s responsibilities and commitment. The fact that a new government is in place with new ideas and priorities, manifested e.g. through RMNCAH, focus on VDCs and *Nsaa Kenno,* is likely to further contribute to CSD´s outreach and quantity/quality of results (there is thus a likelihood that UNICEF also will be held accountable regarding results to a higher extent). (Par 23-26)

[80] The MICS Survey Report, 2018, Table WS 3.1 (per cent distribution of household population according to type of sanitation facility used by the household) shows the following distribution: Banjul 0.3, Kanifing 0.3, Brikama 0.9, Mansakonko 2.4, Kerewan 1.7, Kuntaur 2.5, Janjanbureh 1.7, and Basse 0.7.

[81] Source: Source: Interviews, FGDs, Article in The Lancet: www.thelancet.com/action/showPdf?pii=S0140-6736%2817%2931334-X

10. Which are the factors (internal and external to UNICEF) that hindered the most the success of the previous and current CSD program?

27. The former UNICEF-CSD program was, as was the whole country, negatively affected by weak governance including misuse of resources, contributing to the deterioration of public health infrastructure – leaving the country with significant international debt. Maternal and child health remain serious problems after twenty-two years reign.[82] The lack of coordination among actors in the health sector was a hindrance but also a challenge that was addressed by UNICEF, CSD program staff included.

28. The success of UNICEF-CSD program is closely linked to the MoH´s needs and priorities for support in various areas. It was found that the health system is centralised, leaving the government actors at sub-national level not adequately empowered to make decisions on matters that concern their operations. UNICEF´s reliance on the MoH to transfer resources to be used in the sector limits CSD´s effectiveness. Funds are often not received timely at the regional level and this situation subsequently delays activities that are planned to be carried out in the regions and the districts [83] There is also duplication of efforts in MoH´s division of responsibilities at central level e.g. within the Primary Health, Reproductive Health and Child Health Units respectively of the MoH.

29. The previous CSD program was not subjected to any evaluation which appears to be a lost opportunity that might have hindered the program in reaching its outcomes. It had no designated Nutrition Specialist, nor any designated posts for cross-cutting themes (such as C4D and CSD Officer posts) - which probably hindered the development of these themes. Lack of funds and resources have also been mentioned as a hindrance in the delivery of the program. Factors that may hinder the success of the current program might be the delayed recruitment of some of the vacant posts in the Country Office making it difficult to reach the end of program targets in 2021.

Preliminary Conclusion

EFFEC 7. Poor governance of the former government hindered the development of the CSD program and impacted to some extent the level of effectiveness in the strive to meet the outcomes. Internally, the lack of specialists in the area of nutrition and cross-cutting issues in the Country Office and lack of strategy to tackle the issues of differently abled children also hindered the program to fully reach the outcomes. Funds are often transferred late to the regional health centres and there is a lack of empowerment at the level of the regional directors which reportedly hampers operations at sub-national levels. (Par 27-29)

11. To what extent have unexpected outcomes (positive and negative) occurred as a result of the CSD program activities during the previous and current phase?

30. It has been difficult to identify *unexpected* positive outcomes among the positive work that has been undertaken by CSD. Possibly, you could say that the good effects that NYC had on the public´s awareness regarding WaSH activities were unexpected - at least it appears that the inspiration and energy that young people were able to infuse into the debate was somehow unexpected and led to the realisation that youth has to be more involved in the CSD program.

31. *Unexpected* (negative) outcomes can also be understood as *unintended* negative outcomes. The relatively low demand for health services is an issue that the program (both previous and current) acknowledge and has been trying to address – this could also be referred to as an unintended outcome – although not a result of CSD as such, but rather a systemic issues that concern the CSD and it key

[82] Source: RAM 2015, UNICEF Country Office.

[83] This is a common phenomenon in many countries on the continent, and in developing countries in general. UNICEF Country Office is well aware of the situation and has encouraged the MoH to improve its financial system for increased effectiveness, *one* of the means being the setting up of a PCU, which apparently has materialised during the second quarter of 2019. However, according to UNICEF Country Office, this measure is not fully sufficient. Source: Discussion with the MoH attendants in the presence of the PS, in the Validation Workshop, and in-depth interviews.

partners. Another unintended outcome is the silo effect, i.e. the organisational boundaries between CSD and PIC program - not caused by CSD itself but existing within the UNICEF office. This is something that the program managers, and the UNICEF management are willing to deal with.

Preliminary Conclusion

EFFEC 8. It has been difficult to identify unexpected/unintended outcomes, *caused* by CSD, however, the realisation that young people are willing and able to bring inspiration and energy and act as agents of change in the program is an important realisation and could perhaps be referred to as an unexpected positive outcome. The organisational boundaries between the CSD and PIC programs, and relatively low demand for health services are certainly unintended negative outcomes (and of concern for the CSD program and the CO) but are not caused by CSD´s activities per se – these are systemic issues. (Par 30-31)

12. To what extent did strategic partners and partnerships contribute to the attainment of the CSD program results during the previous and current CSD program?

32. The CSD program works in close proximity with just a few government agencies, that receive funds from UNICEF. MoH, being the key strategic Partner and the regional health centres under this Ministry in the selected program regions, contribute to the program through availing the health system infrastructure, its human resources/staff to participate in various program activities including capacity building, awareness raising events and joint assessments in the field. On the government side, the program also works rather closely with the MoFWR regarding its WaSH activities in relation to water supply, and quality of water in CSD targeted vulnerable regions – in collaboration with the MoH and CSD. For instance, UNICEF´s focal point in this ministry stated that he was heavily engaged in the capacity building on the CLTS approach when it first took off in the health sector 2009, and thus is the "institutional memory" for this activity which will be revitalised through CSD.[84]

33. NaNA which collaborates with CSD regarding its nutrition-related activities, also contributes through availing staff to participate in capacity building and other joint events, and through working on studies related to CSD´s nutrition area funded through UNICEF, related to CSD´s nutrition area, The WFP is an important partner as well and a close working relationship has developed regarding CSD´s nutrition and health related work. NaNA has a rather close working relationships with CSD. It has contributed to child survival through the national nutrition surveys (e.g. SMART surveys) carried out with UNICEF´s support. It also contributes to the CSD program objectives through monitoring the food and nutrition security situation in the country particularly during the critical hunger gap around July – September each year. It is engaged in complementary feeding, micro nutrient issues and management of severe and acute malnutrition (SAM) among children, i.e. IMAM protocol. NaNA receives funds from UNICEF, for the 2 years RWP and transfer funds to the regions for transport (fuel) and drug supply for the health facilities in the selected regions.[85]

34. The WFP also contributes to UNICEF CSD and the PIC programs.[86] Concerning counteracting SAM, it complements UNICEF´s support and supports the same communities as UNICEF e.g. in screening of children under five, and through its feeding classes as part of Early Childhood Education and Development (ECED) for children of 3-5 years in 132 schools in CRR, URR and NB region who get to meals every day from the WFP.[87]

35. At national level the H6 Partnership group is important, consisting of WHO, UNFPA, FAO, WFP, UNAIDS and UNICEF as members (in which the UNICEF management including the CSD Manager participates). The group, which is chaired by WHO, addresses joint programming and specific areas

[84] Source: Interviews.
[85] Source: Interviews.
[86] Source: WFP Country Representative and Nutrition Specialists in interview.
[87] Source: Interviews.

and priorities, including monitoring, evaluation and funding issues.[88] The partnership can be said to indirectly contribute to better UNICEF-CSD monitoring and programming, if not results as yet. Another partner contributing at both national and sub-national level is the National Youth Council that have raised awareness and constructed VIP latrines in rural communities. The Red Cross and HePDO (NGOs) have also contributed to CSD´s work, mainly in terms of their involvement in emergency response.

Preliminary Conclusion

EFFEC 9: It is concluded that CSD has been able to build close working relationships with a few strategic partners in the country. Its closest strategic "allies" in the government (MoH, MoFWR, NaNA) and the WFP contribute to the program in important ways, such as through availing the public health infrastructure at all three levels, human resources, resources in kind and technical know-how through their participating in studies related to CSD´s outcome, and participation in joint field assessments to the CSD focus areas. The H6 Group with its technical working groups in which other UN partners take part, as well as the National Youth Council also contribute to the CSD program results through its attention and interest in improving the situation of children and families in vulnerable regions. However, it is also concluded that contributions to CSD from NGOs has been, and still is meagre which is an area of concern. (Par 32-35)

[88] Source: In-depth interview with a WHO representative.

4.3 Efficiency

13. To what extent are financial resources, human resources and supplies (current program): a) Sufficient in quality and quantity? and b) Deployed in a timely manner?
14. Could less/fewer resources have been used through alternative strategies with the same goals in mind - but with the same or higher level of achievements?
15. To what extent did the partnerships help keep down the costs of program delivery? To what extent did the CSD program budget factor-in the cost of specific activities, outputs and outcomes to address the cross-cutting issues (gender, equity, human rights) mentioned below?

13. To what extent are financial resources, human resources and supplies (current program): a) Sufficient in quality and quantity?, and b) Deployed in a timely manner?

36. a) Sufficient in quality and quantity: It was found that the health sector in The Gambia is heavily centralised. UNICEF program funds are transferred to the MoH for the CSD and PIC program implementation. The Ministry, in turn, allocates/distributes funds to the selected regions that UNICEF supports. An exception is the immunization resources, for which a system is established that enables vaccines, cold storage, funds, equipment and vehicles to reach the regions without delay, i.e. for direct distribution to the Regional Health Centres (RHC). Regarding **financial resources**, the Resident Representative in an in-depth interview stated that the budget for the current Program is "adequate" as it has more than doubled compared to the previous program. This was confirmed by the (then) Deputy Representative in Charge, also Head of the CSD program, at the time. ("adequate" here is meant in relation to the *planned program activities* in supporting the MoH and costs of staff etc – *not* in relation to the magnitude of the needs in the country as such). Unfortunately, despite several attempts to acquire information and data on the current CSD´s real expenditures this information was not made available, thus a detailed assessment on priorities made, for instance, could not be made. However, other efficiency-related information was received, as follows:

37. Regarding the **use of expertise/human resources** within the new CSD program, it was found that there was an improvement in comparison to the previous program as the current has dedicated positions for nutrition (Nutrition Specialist) and crosscutting issues (C4D and CSD Officer). The absence of a C4D Officer was reported as a "challenge" in the 2015-2016 internal review. The reason for the statement is not explained, but it is believed to be related to the need for UNICEF to create more demand for the health services - to be achieved through behavioural change activities involving the key actors in the rural areas.

38. Applying the C4D concept in the Country Office aims at supporting communities and individuals on social and behavioural change and is intended to *create demand* for WaSH and health related services. It has been found that the Immunization Officer post is placed under the Health Specialist post within CSD, which seems too low a placement in view of the responsibilities which includes administration of about 1/3 of the Country Office´s budget.[89] This evaluation has also found that CSD program would benefit from commissioning a Gender Specialist consultant to help develop a Gender Analysis and Gender Integration (mainstreaming) Strategy – both which are missing in the previous and current programs.

39. **Time** is also a resource to be used in a program. There is a perception among *some* CSD staff members that too much time is spent on planning and too little time on actual delivery of the program activities.[90] Thus, making better use of CSD´s staff time could be one way to contribute to higher efficiency.

[89] Source: Interview with UNICEF staff.
[90] This was triangulated from interviews with UNICEF staff, and through the staff survey replies. It cannot be verified that *all* staff members held this opinion.

40. Regarding supplies, in some (not all) health facilities visited, staff stated that medical supplies were not sufficient, and that some equipment were not available. A recent study which CSD has participated in, which carried out inter-agency field visits in the selected areas (CSD MCH Specialist), has looked at this issue among others, which has resulted in a (draft) report provided to the evaluation.[91] The study gathered information in the field as part of the health service system including supplies. It found that the most common reason for illness among children including newborns leading to death depend on these factors (but were not limited to these) are: The severity of the illness; delayed arrival at the clinic; inadequate supplies and medicines; and lack of trained personnel.

41. b) Deployed in a timely manner: An internal report (PPT) in 2017, assessing the RWP mentioned that, regarding Outcome 1, (health) the late disbursement of funds had been a problem at the level of MoH, which resulted in **delayed implementation and impact of activities.** The proposed solution mentioned in this PPT included the establishment of a functional Programme Coordination Unit (PCU) – which in fact was in the process of being set up at the time of the Validation Workshop (mid-May 2019). Several of the health staff in the regional health centres (as well as CREN) who participated in the evaluation, stated that funds from MoH were received late, or very late. The only exception relates to the fund transfers in connection with the immunization campaigns - as this is decentralised meaning the support (in cash and kind) for the campaigns are provided directly to the regions without passing through the central level. It was learnt that in some cases the delay could depend on UNICEF withholding or postponing funds transfer *to the Ministry* at central level, from where the UNICEF funds are transferred to the regional health centres. The reason for UNICEF´s postponed payment to the Ministry at central level, could be an accountability requirement which had not been met. If not met satisfactorily within 6 months, funding from UNICEF can be put on hold.[92]

42. CSD has provided funds to the Ministry based on the program´s RWP, which in turn are based on UNDAF. The funds transferred to the ministry were mainly for capacity development and awareness-raining activities for staff at all levels in the health system. Funds were also delivered for medicines, drugs and equipment to be transferred to the targeted regional health centres. The evaluator was informed by UNICEF that it has no control over "CSD funds" that were transferred from the MoH to the regions and consequently not responsible for any delays.[93]

43. NaNA, which received funds from UNICEF, among development partners, is the agency responsible for coordinating the Government´s nutrition work in the country reports directly to the Vice President.

Preliminary Conclusion

EFFI 1: It is still too early to determine the level of efficiency of the CSD program, at half term. At the time of the evaluation, the level was not very high although the available funds to run the program were assessed by the UNICEF management as "adequate". It is acknowledged that CSD has enabled a more efficient programming compared to the previous one through having more and new cross-cutting expertise in the program. However funds and supplies to the health facilities are often not dispatched in a timely manner by the MoH. (Par 36-43)

14. Could less/fewer resources have been used through alternative strategies with the same goals in mind - but with the same or higher level of achievements?

44. The evaluator has not had access to information on expenditures of the CSD and thus is not in a good position to determine whether "less or fewer resources could have been used through alternative strategies with the same goals in mind - but with the same or higher level of achievements".

[91] Health Facility Assessment study (draft), UNICEF The Gambia Country Office, 2019
[92] IN-depth interview with UNICEF-CSD staff members.
[93] In-depth interview with Deputy Director in charge at the time.

15.To what extent did the partnerships help keep down the costs of program delivery? To what extent did the CSD program budget factor-in the cost of specific activities, outputs and outcomes to address the cross-cutting issues (gender, equity, human rights) mentioned below?

45. Not enough information has been available to answer the first questions satisfactorily. However, the key government, UN and some NGO partners have contributed to the program and thus it is likely that this has kept down the costs, by making available its health infrastructure, information systems, personnel and more, i.e. *in kind* contributions such as fuel for transport. Joint field assessments, performance monitoring, and H6 group assessments are made which are mutually benefitting efforts and which could be done to a greater extent.

46. Also as regards the second question, not enough information has been shared to what extent the program has budgeted for specific activities, outputs and outcomes to address the cross-cutting issues. The only document provided to the evaluator that allows assessing the factoring-in costs for specific cross-cutting issues is the *newly* drafted rolling work plan for 2019-2021 in which **only one costed activity specifically mentions a cross-cutting issue** "Conduct immunization equity assessment". The rest of the budget lines do not indicate that the CSD for the coming two years will include, or address, cross-cutting issues i.e. gender, equity including issues related to differently abled children or mothers, or human rights and the work on birth registration for which CDS is cooperating with PIC is not visible in the budget.[94]

Preliminary Conclusion

EFFI 2 The evaluation does not have access to information to make robust conclusions on expenditures – i.e. how they have been affected through partnership with others and to what extent the program budgets have had allocations (and expenditures) for specific cross-cutting issues (gender, equity, human rights). However, through its partnerships with a vast array of stakeholders, it is a) likely that costs for program delivery have been kept down to some extent and b) expenditures and budget allocations for cross-cutting issues per se is not any significant part of the CSD budgets allocations or expenditures.(Par 45, 46)

[94] Well aware that the observation concerns the future – not the past – and therefore goes beyond the evaluation chronological scope - it is assessed to be a significant observation. See also the findings and conclusions in Section 4.6. Gender, human rights and equity.

4.4 Impact

16. To what extent has the UNICEF CSD program contributed to the reduction of childhood illnesses and child mortality, and maternal mortality?

To what extent has the UNICEF CSD program contributed to the reduction of childhood illnesses and child mortality, and maternal mortality?

47. In the country *overall*, childhood mortality has been reduced - with the exception of neo-natal mortality as this report shows.[95] It is assessed that it is *very likely* that UNICEF-CSD has had a positive impact in reducing childhood illnesses and child mortality of children under five - through its regular country-wide vaccination and deworming campaigns. Through policy advocacy; supply of medicines and equipment and developing awareness and knowledge on PMTCT; essential care practices, nutrition and WASH in the most vulnerable regions; and raising the capacity and skills of staff - CSD has clearly had a key role in reducing the rate of childhood illnesses and mortality.[96]

48. At village level, the majority of the respondents acknowledged that there clearly had been changes for the better during the last decade. Village Health Workers, Community Birth Companions, and Village Heads were among the people who acknowledged, in interviews and FGDs, that there has been a reduction in malnutrition, in the prevalence of disease such as pneumonia and malaria among children - although they were not always aware of the role of UNICEF-CSD. There was also acknowledgment that there had been an increased awareness among women and families about the importance of care for new-borns.

49. Regarding the situation of neo-natal (newborn) mortality, rates have not moved downwards in the country in the last two decades. Severe and acute malnutrition among children is still a serious problem in the vulnerable areas during the months of July-September when less food is available on the tables in the rural households, in particular in the vulnerable regions that UNICEF has support activities[97]. Regarding maternal mortality, the rates are still high and not enough information has been available to know the extent of UNICEF´s impact in reducing the occurrence in maternal morbidity in the selected program regions. However, MoH health staff and volunteers participating in the evaluation expressed confidence that UNICEF has contributed positively in reducing the rate through supporting preventive measures, knowledge transfer and raising capacity of health staff and volunteers. Areas that were frequently mentioned were emergencies related to child birth, advise in connection with pregnancy and child birth, malaria prevention and PMTCT .

50. Regarding the use of improved drinking water sources, any causal links between UNICEF CSD´s activities to suggest impact were hard to find but it is possible that UNICEF-CSD has contributed to improvements. There is a good chance that there will be positive impact in this area in the coming years as CSD together with the government counterparts will revitalise the CLTS approach during the current year jointly with NGOs.

Preliminary Conclusion

IMP 1. It is assessed that a *likely* impact of the previous CSD program is that it has contributed to improving the health status of children under five, and reducing child mortality rates in the targeted regions. However, it has not been able to impact positively in reducing the rates of neonatal mortality. Impact at institutional level through knowledge sharing and building capacity of staff is also likely. As regards the current CSD program, it is too early, at mid-term, to determine impact. (Par 47-50).

[95] See the details from MICS in section 1.2.2.
[96] The assessment comes from triangulating documents, interviews and FGDs – however, the improvements cannot be solely attributed to UNICEF-CSD program, as there are other actors involved.
[97] Source: In-depth interview with CREN staff, UNICEF and MoH staff.

4.5 Sustainability

17. What mechanisms (if any) were put in place for/by the Government to enable continuation of certain key CSD approaches during the previous program period (e.g. benefits, systems, knowledge, human resources, funding for supplies, drugs, vaccination campaigns)?
18. To what extent (if at all) have CSD program strategies and activities been replicated by the Government and other partners?

17. What mechanisms (if any) were put in place for/by the Government to enable continuation of certain key CSD approaches during the previous program period (e.g. benefits, systems, knowledge, human resources, funding for supplies, drugs, vaccination campaigns)?

51. The evaluation has not come across any dedicated activity (e.g. workshop, seminar or capacity building event) or report that *addresses sustainability issues*. In order to inquire how the Country Office has approached sustainability over the years, and how CSD has looked at the concept, the evaluation has identified how it has been mentioned in external reviews and reporting on country programme progress and brought it up in interviews and FGDs.

52. It was found that the In-Depth Review (2014) did not bring up sustainability in any specific way, or as part of recommendations in connection with the CSD program (but more in connection with PIC). It only mentions that downstream interventions needed to be supported by high-level upstream commitment and advocacy for sustainability and ownership.[98] In 2016 it was mentioned that a number of factors had constrained the work on progress for children, the key being sustainability of WaSH facilities in schools and the weak capacity on effective hygiene promotion skills.[99] In 2017, in connection with the Building Resilience through Social Transfers for National Security in The Gambia (BReST) program, UNICEF has mentioned that it aims to contribute to lowering the malnutrition rates in the country through building a *sustainable* social protection mechanism to afford cash transfers to all mothers covering the 1000-day period.[100] However, the actual sustainability of this mechanism remains to be determined as it was too early to know at the time of this evaluation.

53. The evaluation found that respondent in interviews and FGDs mentioned sustainability being linked to VDC being acknowledged as the centre for all community interventions. This will strengthen demand for essential care and healthy practices, being part of the *Nsaa Kenno* strategy, and is expected to create greater sustainability of all activities. The Annual Report 2018 mentions that the program had worked toward a sustainable use of WASH facilities through training of 130 Water Management Committees and Mothers Club members (latrines and water points). The need to identify potential partners across the three tiers of governance structures to deliver results for children, is mentioned and strengthening "groups, platforms, and spaces" at national, regional and community levels to generate positive changes for children and ensure sustainability.[101]

54. Regarding funding for supplies, equipment, drugs and vaccination campaigns these are areas that still very much are dependent on donor funds, including UNICEF funds. Regarding the "software" aspects of UNICEF-CSD support such as benefits, systems and knowledge, UNICEF places a lot of importance on building capacity of staff within the health sector however the attrition is a serious problem in the Government, and as long as this continues, staff training is likely to constitute a large part of the UNICEF program. The evaluator talked with some health volunteers who have important functions at village level but who claimed that they had been attending training events "a very long time ago" and that they were eager to be involved in more events to learn more.

55. Although the work done so far has not generated a totally ODF free environment as was a 2017 goal set by the former President, the efforts made over the years have had positive effects, and the knowledge

[98] Source: IDR, 2014.
[99] Source: RAM report, 2016, UNICEF Country Office.
[100] Source: COAR 2017, UNICEF Country Office. BReST program is implemented by UNICEF as a three year action in partnership with NaNA in NBR, URR and CRR, funded by the European Union.
[101] Source: COAR 2018, UNICEF Country Office.

generated from the CLTS approach is not lost – but difficulties have been experienced in some riverine areas as mentioned in this report. CSD will be extending its coverage to more areas in 2019 (plans were under way at the time of the evaluation visit) and a Guide (draft) was being developed at the time when the evaluator visited The Gambia, to be used in training at sub-national level.[102]

Preliminary conclusion

SUST 1. The evaluation has assessed that the increased coordination and joint field assessments, the *Nsaa Kenno* and treating the VDC as an entry point to the services offered/directed to the rural communities, most probably have been enabling conditions for sustainability and can be viewed as an important mechanism for all government-supported actions. (Par 51-55)

18.To what extent (if at all) have CSD program strategies and activities been replicated by the Government and other partners?

56. The MoH´s has adopted UNICEF CSD strategies and activities over the years. Information was received that some of the MoH sections/staff deployment, had been created to reflect the content of UNICEF´s program, possibly in order to align with funding opportunities – which possibly could be seen as a replication of CSD strategies (such as the units of Primary Health Care (PHC), Mother and Child Health (MCH), Prevention of mother-to-child transmission (PMTCT), Reproductive and Maternal Child Health Services, RMNCAH, Integrated Management of Neonatal and Childhood Illness (IMNCI), Expanded Programme for Immunization (EPI)).[103]

57. The work on CLTS and WaSH resulted in the fact that Open Defection (OD) issues were acknowledged at the end of the previous program cycle and is now an inter-ministerial issue for MoFWR and MoH). At sub-national level, the essential care practices, household behaviour change messages for the health staff to promote are program strategies which also could be said to be "replicated" by the MoH. UNICEF country programme management has expressed the need for the MoH and other government ministries and agencies, to become stronger on ownership of the donor funded programs, as well as more accountability and openness vis-à-vis the government from the part of UNICEF and other UN agencies in the coming years. A discussion had been initiated by the new UNICEF Country Representative with the other UN partners on how they could all contribute to a change in this respect. This had not progressed much at the time of this evaluation.[104]

Preliminary conclusion

SUST 2. A number of UNICEF-CSD strategies have been adopted by the MoH over the years: At national level several units can be said to have been replicated from UNICEF program such as Primary Health Care (PHC), Mother and Child Health (MCH), PMTCT, Reproductive and Maternal Child Health Services, Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH), Integrated Management of Neonatal and Childhood Illness (IMNCI), Expanded Programme for Immunization (EPI). At sub-national level strategies of essential care and behaviour change practices can also be said to have been replicated from UNICEF-CSD approaches and program. (Par 56 - 57)

[102] Source: Interviews with several UNICEF staff and ex-staff, Government officers and document review.
[103] Source: Interviews with UNICEF staff.
[104] Source: Interview with the UNICEF Resident Representative.

4.6 Gender, human rights and equity

58. This section addresses cross-cutting issues i.e. gender, human rights and equity, in particular it looks at how the CSD program has been able to duly integrate these issues in the design and delivery of the program. It also attempts to determine to what extent the CSD programme has been able to remove the barriers that prevent girls´ and women's access to the services that it made available in the targeted communities.

4.6.1 Integration in the design of the program

59. In the overall design of the current UNICEF Program Document (2017-2021) it was mentioned that a gender lens should be used throughout the programming in line with the 2014-2017 UNICEF Gender Action Plan, *but with a focus on child marriage and girls' access to education*.[105] However, gender issues have been just as important in the three CSD core areas of maternal and child health, nutrition and WaSH. The CSD program has acknowledged that gender disparities and harmful traditional practices affect the health status of girls and women, i.e. FGM and early marriage. The previous CSD program (2016-2017) mentions "women", "children" and "mothers" in the PCRs and progress indicators, but there is no mention of "girl" or "boys").

60.When scrutinizing this document, and its related plans and results matrices, it is clear that it has intended to address and meet the needs of girls, adolescent girls, boys and women within the three outcome areas and that gender was to be integrated in the program but it did not explicitly propose any strategy on how this should be done. The outcomes and outputs have mentioned gender and stated that the program should contribute to strengthening the health, WASH and nutrition systems and deliver inclusive and quality services for these "categories"/genders. It intended to deliver inclusive and quality services also in cooperation with the PIC program, on mitigating girls´ early marriage and counteracting girls' dropping out from school.

61.Human rights has been is mentioned in the overall UNICEF Program design only in reference to the (then) draft UNDAF. Regarding equity, the term was part of each of the three outcomes. It has been mentioned that the Country Office had intended to focus on preschool education and the promotion of inclusive education for girls, children with disabilities and children attending Madrassas and Koranic centres (*Daras*), among other disadvantaged groups.[106] However, in the revised CPD matrix for the CSD program it has only been mentioned in reference to strengthening the equity-based databases in the country.[107]

4.6.2 Integrating gender, equity and human rights concerns issues in program delivery

62.In the actual implementation and delivery of CSD, there are a number of gender-specific and equity related, even human rights related dimensions of the program exemplified below:

63.Regarding gender (and equity), CSD has supported the public health system to offer quality services related to *girls, boys and women* in the selected vulnerable regions through offering services in health clinics, schools and household level, and raising awareness on the need for household behaviour change and has increased the demand for these services. Although the main focus has been on children under five, it has also worked with PIC on *girls´ rights to enjoy an education* through advocacy and actual construction of toilets/latrines, hygiene units and quality water in schools specifically benefitting *adolescent girls*. This was intended to increase their demand for education and prevent them from leaving school ("dropping out") and enter early marriages. CSD has also supported water and sanitation facilities for *women-headed households* – and in some Madrassas.

64.The Cash Transfer program of the PIC, supported also by CSD, has benefitted *women* living in poverty with *new born children* for the first 1000 days. In 2018, 6176 women were registered to receive

[105] Source: The Gambia UNICEF Country Programme Document, 2016
[106] The Gambia UNICEF Country Programme Document, 2016.
[107] Source: Revised CPD Matrix for CSD

money on a monthly basis for the first 1000 days in CRR, URR and NBR, aimed to improve nutrition and build resilience. This activity is *both gender and equity responsive*. The CO has realised that various Partners, were involving the same government structures, which resulted in uncoordinated actions. With the aim of increasing both **access** and demand for health services, and *removing barriers for vulnerable girls and women*, more coordinated actions have been taking place in the new CSD program through the *Nsaa Kenno* approach.

65. However, no specific guideline has been found on how to integrate gender (or human rights or equity) in a systematic way in the CSD program implementation, or how to design or implement monitoring systems and follow-up to specifically capture these issues that cut across the whole program. CSD has not been able (yet) to clarify vis-à-vis its government partners that the gender as a concept refers to girls, women, boys and *men,* and no strategy has been identified on how to ensure that all genders have a **voice** and contribute to the CSD program and results. The understanding among respondents were that it was the *mothers´ or women's´* responsibility only, to ensure children´s health.

66. It is noted that the In-Depth Review (2014) - which has been the only external review/evaluation conducted of the CSD program since before 2012 - missed an opportunity to provide guidance on gender integration in implementation, in preparation of the current CSD 2017-2021 cycle. The following recommendation in the In-Depth Review report: "Align the current programme with the Gender Action Plan (GAP) for the region" has provided little guidance and seemed not to have been addressed in the CSD program. It also states as follows: "During the discussions on equity and gender, the small nature of the country office and limited capacity to mainstream gender in programmes due to the small number of staff was highlighted. However, the country team was informed of the newly appointed Gender Advisor at Regional Office who is in the process of developing guidelines for country offices in the region to align their programmes with the GAP. *This may involve appointing one staff member in the country office* (evaluator´s italics) to focus on meeting the requirements of the GAP, and changing their contract to reflect the duties that come with managing the GAP".[108]

67. Although the management and several of the staff members were concerned about gender issues in the program, the evaluation did not find evidence that any particular staff member in the office had assumed the role of meeting the requirements of the Gender Action Plan (GAP).. Nor has it found any evidence that any workshops or training courses/seminars that were held specifically have addressed gender, equity or human rights topics - neither in the current nor in the former CSD program – i.e. related to analysis, strategy/approach or implementation, or aiming at training or building capacity of staff on these issues. Further, voices from the *field*, from women, men, adolescent girls, and elderly were scarce in the CSD program documentation.

68.In relation to equity, CSD´s down-stream approach has involved catering for the needs of the most vulnerable population residing in the areas where the socio-economic indicators are the poorest and where impact can be generated (URR and CRR). Within these regions, the majority of the villages have been outside the regional health circuit – and hosts the least number of inhabitants. The health sector actors have referred to these as "Non-PHC villages." At national level it was expressed in the Validation Workshop from high level that it was not feasible to spread the government´s health services to Non-PHC villages as this would entail unreasonable costs – instead the people would have to move closer to the health centres.

69.At sub-national level the opinions on these issues were different. Some respondents expressed that there were Road Maps and plans in the making on how this would happen, through recruitment and placement of trained nurses to reside in remote villages. Several health staff and volunteers expressed the same views and some indicated that they were waiting for the Government to progress on this issue.

70.Regarding equity and children on the move and/or children without any documents - the health centres visited stated that they do not refuse treating any children who come to the clinics, referring to

[108] IDR report 2014, p. 23, para 3.5.3,

the fact that they receive and treat children and mothers from Senegal and even other countries.[109] In respect to equitable access to immunization services, pockets of low coverage have existed in the country, including in densely populated urban areas. Low coverage in urban areas was explained by the limited infrastructure and capacities. For example, waiting time in poor conditions (standing up, poor ventilation, etc) has led to reduced attendance during immunization campaigns. This has partly explained the lower demand in such areas.

71.CSD had aimed to work closely with PIC on making community services accessible to children (girls and boys) who are differently abled (earlier: children with disabilities). The evaluation has however not been able to identify any evidence that CSD has specifically addressed the needs of these children, or their mothers, in health clinics or in communities – with the exception of some activities catering for differently abled during the 2016 emergency crisis. The Department of Health Services (DHS) has collected information on children who are differently abled but only information that is self-reported - despite the fact that it is likely that the number of children under five, who are differently abled and suffer from health related ailments are likely to be significant.

72.In relation to offering of health care services, including PMTCT of HIV and immunization against children´s diseases and de-worming, the program focuses on interventions in most vulnerable regions in the country which is an adherence to the equity concept and inbuilt in UNICEF´s approach per se. However, there clearly are differences in access to, and demand for services within the regions. In a UNICEF-commissioned Situational Analysis it was found that urban children whose mothers have primary and secondary or higher education are more likely than rural children to be treated appropriately. It stated: "Children with fever in Basse, where malaria is known to be most prevalent, are the least likely to have received appropriate anti-malarial drugs while those in Kerewan are the most likely to receive an appropriate drug."

Preliminary conclusion on gender, human rights and equity principles duly integrated in the design and delivery of the programme

In the design of the program, the current UNICEF Program Document (2017-2021) (Section on CSD Program)[110] has mentioned that these issues should be integrated in the program but has not explicitly proposed any strategy on how this could be done. No operational plan has been identified that outlined any systematic approach to integrating (mainstreaming) gender in the program. Equity has been part of each of the three key Outcomes, but neither human rights nor equity integration were explained in the document. The previous UNICEF Program Document 2016-2017 (section on CSD program) was even less specific on gender issues; Here, although women, children and mothers are specifically mentioned in the PCRs and progress indicators, curiously there was no mention of girls or boys.

In the delivery of the program, regarding **gender integration**, CDS program have focused on meeting the health, nutrition and WaSH needs of *girls, boys (mainly under five) and women*. It also addresses needs of their *mothers/female* caregivers, *adolescent girls* and *female-headed households* in various ways - including social protection measure through cash transfers to mothers with newborn children. The evaluation has, however, not found any strategy, documentation or information through interviews indicating that CSD is concerned about, or strive to address also *men/fathers or elderly (women, men)* in order to involve them in the program to contribute to the outcomes.[111] There is also scarcity of voices from the field in the program documentation. Regarding **equity integration**, this is part of UNICEF´s principles per se, and the CSD program has to date focused on the most vulnerable regions. However, there were clearly differences in access to, and demand for services within the regions and no strategy existed on how to provide services, and increase the demand in the Non-PHC areas, or how to cater for the needs of children who are differently abled. Equitable Access to vaccinations were not fully equitable in the nation-wide immunization campaigns. As for rights issues integration, the support to

[109] No records were accessed that could verify these statements.
[110] The Gambia UNICEF Country Programme Document, 2016, Revised CPD Matrix for CSD.
[111] If this was done in, for instance, in the CLTS capacity building, training or in communities - no documentation or interview response has been identified that explain how it has been done (strategy), or its purpose.

girls´ rights to an education was something the CSD had supported through for instance ensuring girls´ access to toilets, water and hygiene units – to counteract girls leaving school and entering marriage. (Par 58-72)

5 FINAL CONCLUSIONS

This chapter includes the final conclusions, based on the findings and preliminary conclusions in Chapter 4. It also has a discussion on lessons learnt.

5.1 Relevance

The CSD program is relevant in its policy alignment and unique role among the other UN and international agencies in working for child survival and development for children under five years of age.

5.2 Effectiveness

Regarding the previous CSD program (2012-2016), the information received points to elements of the program that were effective: vaccinating children against infectious diseases, promoting household behaviours and supporting the government in revitalizing the PHC strategy. Surveys in the field of nutrition reportedly led to evidence-based planning, assessment and policy advocacy. It was able to influence the policy level in areas that related to its program and succeeded in placing the spotlight on water and sanitation issues in its advocacy for girls´ right to an education, which through UNICEF-CSD´s continuous efforts have become an inter-ministerial issue.

The CSD has throughout placed emphasis on institutional development and staff capacity development for the various categories of government staff and volunteers in both programs – a very important element that cannot end due to the attrition within the government at all three levels, as well as the need for refresher training, and training of village and community volunteers assuming responsibilities for Maternal and Child Health (MCH) at field level. CSD has contributed to reduced child mortality and malnutrition in the country, however, the high rates of neo-natal mortality have not improved and therefore new strategies and more targeted efforts are needed in the coming years.

The new CSD program (2017-2021) has in its design placed more emphasis on "equity" and "behaviour change", and linked to the health outcome "rights" was added. In delivery, it has placed more focus than the previous on access to, and demand for, PHC services and water and sanitation facilities. The program is focused on "using" the VDC as an entry to the villages and communities and is active in coordinating efforts with the MoH and its close Partners in undertaking joint field assessments, spread messages and encourage demand for services. The evaluation has identified some issues that are critical: the absence of a gender analysis and gender integration in policy/plans; scarcity of voice from women, men, girl and boys reflected in the program documentation - regarding their perceived needs and constraints; the low participation of NGOs/CSOs and "champions" as partners in the implementation; lack of a strategy on how to reach children who are differently abled; and organisational boundaries between programs within the UNICEF Country Office, that are likely to reduce the level of effectiveness.[112] Finally, it was found that the health system is centralised, leaving the government actors at sub-national level not adequately empowered to make decisions on matters that concern their operations.

5.3 Efficiency

The evaluation has not had access to information and expenditure data to make a definite conclusion on efficiency. However, it can be concluded that the level of efficiency may not have been high. high. Although the boosting of financial allocations, human resources and expertise has taken place, it is likely that the efficiency of the CSD program has been undermined by the Government's rather limited capacity to assign adequate and timely resources to the health facilities in the region (except for immunization).

5.4 Impact

Regarding the previous CSD program it is assessed that it has very *likely* had a positive impact in improving the health status of children under five, and reducing child mortality rates in the targeted regions. Impact at institutional level through knowledge sharing and building capacity of health sector staff is also likely even considering the attrition rate in the public health sector. However, not enough information has been available regarding impact in reducing neonatal and maternal mortality rates in the selected regions. As regards the current CSD program, it is assessed to be too early, at mid-term, to determine impact.

5.5 Sustainability

As the public health system, including the MoH, as well as the National Nutrition Agency (NaNA), is still dependent on support from development partners (donor agencies), sustainability cannot be determined as achieved. However, *certain domains* of intervention, such as child health, nutrition and WaSH have been increasingly integrated into government programmes, which suggests that such activities *could* continue even without UNICEF support, although at a much lower degree, due to shortage of Government funds.

5.6 Gender, human rights and equity integration in program design and delivery

The conclusion is that CSD´s attention to gender, human rights and equity is not sufficient. In the design of the program, the UNICEF current Program Document 2017-2021 (Section on CSD Program) mentions that gender should be integrated in the program but does not explicitly propose any strategy on how this should be done – nor have this evaluation come across any operational plan on gender integration (mainstreaming). Equity is a term which is part of each of the three key Outcomes, but neither human rights nor equity integration are explained in the document. The previous UNICEF Program Document 2016-2017 (section on CSD program) is less specific on gender issues; Here, although women, children and mothers are specifically mentioned in the PCRs and progress indicators, curiously there is no mention of girls or boys. Thus, in both programs (current and previous), gender as a concept related to the needs of children (girls and boys), their mothers, adolescent girls, ***men and fathers*** - are hardly referred to in the documentation - *with the result of the latter not being sufficiently engaged during the programme implementation.* The voice of the different genders are also scarce in the program documentation.

Regarding equity, there clearly are differences in access to, and demand for services within the regions and no strategy exists as yet on how to provide services, and increase the demand, to children and mothers in the Non-PHC areas, or how to cater for the needs of children who are differently abled. Equitable access to vaccinations in the nation-wide immunization campaign also need to be improved. As for rights issues integration, the support to girls´ rights to an education is something the CSD has supported through for instance ensuring girls access to toilets, water and hygiene units – to counteract girls leaving school and entering marriage.

6 LESSONS LEARNED

These are the evaluation´s assessment on lessons learnt:

1. All UNICEF Programs, and those of its Partners and key stakeholders (nationally, regionally and globally) need to document its *own* lessons and ensure that there are internal and regional dialogue and sharing, specifically related to learning from implementation – including learning from what has worked and what hasn´t worked.
2. Despite the push for convergence and inter-sectoriality in CSD, the creation of separate sectoral outcomes (e.g. health, nutrition and WaSH) in The Gambia CSD program is likely a result of lessons learnt from the previous program. A lesson that can be generalised is that this may be necessary for accountability reasons but that convergence between the "areas" must be dealt with so as to avoid silos as reported on here.
3. The prevailing malnutrition issues and high mortality rates for neo-natals also triggered the UNICEF Program to push forward the UNICEF nutrition agenda to have a permanent nutrition specialist post in The Gambia for more technical expertise which also was the result of a lesson learnt and a very important in creating working relationships with for instance NaNA, and MoH. A lesson to be generalised beyond The Gambia is thus to ensure that the program´s outcome areas are matched with suitable technical expertise.
4. While it is estimated that only around 1 per cent of the households still practice OD, in some riverine rural communities that have high water levels, communities experience difficulties in constructing and maintaining latrines which is not necessarily because of a lack of interest in the community to reach OD status (and be declared ODF) but has clear technical aspects to the problems. The lesson learnt that can be generalised beyond The Gambia is that social and technical problems related to water and sanitation issues with adverse effects on the health status of children (and families) are intimately connected, and therefore a holistic solution need to be sought in order to progress on health outcomes.
5. Duplication of efforts in the government division of responsibilities for child survival were found to exist within the MoH.[113] Given the proximity of CSD and PIC staff within UNICEF and of the different Government agencies that work on health, nutrition and WASH (that entails the risk of duplication of efforts), continued information sharing and communication are needed, both within UNICEF and between UNICEF and its other key partners and stakeholders.
6. The involvement of CSD staff in joint field assessments of health facilities with the MoH colleagues has proved an important tool to strengthen the monitoring of the quality and quantity of the MHC services offered in vulnerable regions. This is a lesson which easily can be generalised beyond The Gambia, and beyond the UNICEF and is an important learning for all UN agencies working with technical assistance with Government agencies.

[113] This was triangulated and also presented and discussed in the Stakeholders meeting on 16th May in which the PS and many staff members of the MoH and others attended.

7 RECOMMENDATIONS

The following are recommendations based on the key findings and conclusions. These recommendations were developed in a participatory manner: UNICEF Country Office staff and other government counterparts discussed the feasibility of their implementation and figured out key related activities to implement over the next 24 months. This process was coordinated by the Regional Evaluation Adviser.

Table 7. Recommendations (strategic and operational)

	Recommendations	**Reference to conclusion sections 4 and 5.**	**Priority**
	Strategic recommendations		
1.	**Strategic Recommendation** 1 (aimed to Government of The Gambia: MoH, MoFWR, MoWACSW and NaNA) In close cooperation and with UNICEF support, and in cooperation with key UN agencies - develop a Community Health Policy and a Strategic Plan that clearly explains how MCH, Nutrition and WaSH services can be accessed by children and mothers who live in the remote **Non-PHC** villages, in areas with the poorest socio-economic and health status indicators, including Kuntaur and Brikama – in cooperation with and other key partners.	Preliminary conclusion EFFEC 5 (section 4.2) and Final conclusion (section 5.2)	**High**
2.	**Strategic Recommendation 2** (aimed to UNICEF CSD and Government of The Gambia: MoH, MOFWR, NaNA) a) Develop a strategy to build up a long term, involvement of NGOs/CSOs and private sector champions for social mobilisation and knowledge, specifically on CSD. This would require capacity development of potential organisations; and b) Prepare for representation of informed CSOs/NGOs in technical working groups and joint field assessments.	Preliminary conclusion EFFEC 4 (section 4.2) and Final conclusion (section 5.2)	**High**
3.	**Strategic Recommendation 3** (aimed at UNICEF CSD and management) Address the issue of the institutionalised silo in the Country Office and promote more convergence and synergy around various parts of the CSD programme (Health, Nutrition, WASH and C4D). One way to tackle this is	Preliminary conclusion EFFEC 5 (section 4.2) and Final conclusion (section 5.2)	**Medium**

	through creating a Community of Practice (CoP) that can cross organisational boundaries between CSD, PIC (and also the Program Effectiveness (PE)) – which would build on common interests, increase competences and enable knowledge transfer. Another way is to *jointly (*all programmes) create a Theory of Change (all sections).		
4.	**Strategic Recommendation 4** (aimed to UNICEF CSD and Government of The Gambia- MoH, MoFWR, NaNA, MoWACSW) Develop a strategy, including monitoring and follow-up, on how children and mothers who are differently abled may access and use health services.	Preliminary conclusion EFFEC 5 & 7 (section 4.2); Preliminary conclusion on gender, human rights and equity; and Final conclusion (section 5.2)	**High**
5.	**Strategic Recommendation 6** (aimed to the Government of The Gambia – MoH, MoFWR, NANA, MoWACSW) In close cooperation with UNICEF, develop tangible and measurable outcomes for delivering gender responsive messages to the public - including *men* (fathers, and to-be fathers), women, adolescents and children on how to prevent illness, child and maternal mortality.	Preliminary conclusion on gender, human rights and equity (section 4.6) and Final conclusion (section 5.6)	**Medium**
	Operational recommendations		
6.	**Operational Recommendation 1** (aimed at UNICEF CSD) Gather and document lessons from the field in a structured and systematic manner that give voice to girls, boys, women and men in the CSD selected vulnerable areas. The purpose would be to enable a more "informed" dialogue with the Government at policy level. This could be done through a participatory Reality Check Approach (RCA) and should involve voices (women, men, girls and boys) from the Non-PHC villages.	Preliminary conclusion on gender, human rights and equity (section 4.6) and Final conclusion (section 5.6)	**Medium**
7.	**Operational Recommendation 2** (aimed to the Government of The Gambia)	Preliminary conclusion EFFEC 7 (section 4.2)	**High**

	Empower the sub-national actors (regional health Directors/health teams) in the Local Government Areas in terms of budgeting and decision-making in matters that directly concern their operations.	and Final conclusion (section 5.2)	
8.	**Operational Recommendation 3** (aimed to UNICEF CSD): Obtain a technical support from Gender Specialist to help develop a Gender Analysis and Action Plan for integration of gender concerns in the CSD program, including capacity development for newly recruited staff. This could also include ways and means to ensure integration of equity and human rights concerns. This can be done through developing a ToR for consultant, request support from the regional office, stretch assignment among others.	Preliminary conclusion on gender, human rights and equity (section 4.6) and Final conclusion (section 5.6).	High

ANNEX I. TERMS OF REFERENCE AND BIO-DATA OF THE CONSULTANT

Consultancy to support the formative Evaluation of the UNICEF Child Survival and Development Programme in The Gambia (2017-2021)[114]

1. Evaluation Object

The UNICEF – Country Programme Document (CPD), 2017 – 2021, has two programme components:

- Child Survival and Development (CSD)
- Protection and inclusion of children (PIC)

The first one of such components (CSD programme) is expected to attain outcomes in three principal areas: health, nutrition and WASH (see Box 1 for more details). In addition, the CSD programme is geared towards strengthening the following: (i) upstream policy advocacy; (ii) technical support to key in-country stakeholders (iii) downstream community-based systems and services; and (iv) intersectoral collaboration and coordination at the community level.

Box 1. CSD Programme Theory of Change in Health, Nutrition and WASH

1. **CSD Programme Outcomes in Health**:

The UNICEF theory of change states that ***if*** Gambian children and women have access to and utilize improved and equitable quality maternal and child health services, learn and practice healthy behaviours, ***then*** children will benefit from immunization and other preventive services, childhood diseases will be recognized and treated appropriately and maternal, neonatal and child mortality will be reduced.

However, for this hypothesis to hold, it is important that the major bottlenecks identified in the health sector in The Gambia be adequately addressed. Such bottlenecks include the following :

- Limited institutional capacity at upstream level in developing and implementing sectoral development plans and policies by promoting intersectoral coordination and mobilising financial resources from government and donors;
- Weak and inadequately funded Primary Health Care (PHC) system;
- Inadequate staffing, weak supply chain management, inadequate funding, weak information management systems and poor adoption of optimal health practices;
- Very few development partners and donors present in the country which contributes to limited resource mobilisation;
- Limited knowledge and awareness on health practices at community and family levels.

In line with the Government's sectoral priorities, the CSD programme includes three outcomes for health:

Output 1: A strengthened PHC system that provides equitable and quality maternal and child health services for all girls, boys and women.

[114] To be noted: this is the second TOR that the consultant received and the one which the evaluation is using.

The theory of change states that *if* the Government is supported in developing and implementing better policies and strategies, improving its coordination system and allocating adequate financial resources, *then* the accountability and technical capacities of the PHC system for scaling up health interventions will be strengthened.

Output 2: Communities acquire positive behaviour and demonstrate enhanced demand for health services, with particular focus on the neonatal period.

The theory of change states that if communities acquire positive behaviour and demonstrate enhanced demand for health services, parents and other caregivers will demand and utilize better health services and care practices for their children.

Output 3: Community-level capacities are strengthened to deliver quality maternal and child health services.

The theory of change states that *if* community structures are able effectively and successfully to promote improved healthy behaviours, then community members, parents and other caregivers will have access to improved quality health services for themselves and their children and begin to practice the healthy behaviours.

Each one of these three outcomes addresses both upstream policy advocacy and downstream community-based systems and service delivery and emphasizes strengthened inter-sectoral coordination at community level as well as programme for protection and inclusion of children. Social behavioural change communication has been regarded as critical to the downstream activities, and has included training of communications staff in community-based approaches. Programme stakeholders include facilitators, community social mobilizers, journalists, community champions, programme managers, health workers, CSOs and researchers.

2. CSD Programme Outcomes in Nutrition:

The CSD Programme will focus on the fact that ***if*** all children, adolescent girls and women, especially the most vulnerable, realize their rights and utilize equitable and quality nutrition services and nutrition and care practices, ***then*** the rates of stunting, wasting and micronutrient deficiencies will decline, especially among children in the first 1,000 days of life; children with severe acute malnutrition will be treated appropriately; and under-five mortality will be reduced. Joint United Nations efforts on nutrition includes support for the SUN initiative through the Renewed Efforts Against Child Hunger and Undernutrition and Global Alliance for Resilience initiatives

The recent nutrition bottleneck analysis identified the following key bottlenecks for nutrition:

- Inadequate coordination mechanisms at the national and regional levels. The National Nutrition Council, hosted and chaired by the Vice- Presiden t, coordinates all nutrition-related work. The

Gambia also established the National Nutrition Agency under the office of Vice-President with the overall mandate to coordinate implementation of the nutrition policy and strategy through the National Technical Advisory Committee. The latter is also serves as an interface between the Government and all other partners, including coordination for the SUN movement. In practice, however, nutrition is still widely considered as an issue for the National Nutrition Agency and there is no coordination mechanism for nutrition at the regional and lower levels;

- Very few development partners and donors represent in the country, which contributes to limited resource mobilization on nutrition. The situation is compounded by the limited funding from the Government for nutrition interventions;
- Inadequate staffing in most of health facilities due to weak implementation of the deployment policy which limits service delivery. This is compounded by the high attrition rates with staff leaving the system for new jobs or higher education;
- Weak supply chain management system;
- Inadequate information management systems to inform decision-making in programme design and implementation;
- Inadequate skills and tools for health workers to support and counsel caregivers to ensure adoption of optimal nutrition practices.

In line with the Government's sectoral priorities, the CSD programme includes two outcomes for nutrition:

Output 1: A national nutrition system is strengthened with capacities to respond to shocks and meet community needs in providing equitable and quality nutrition services.

The theory of change states that *if* at national level, government capacities (policies, financing, coordination, accountability and response to shocks) for nutrition are strengthened, *then* children and women will be able to access and utilize equitable and quality nutrition services.

Output 2: Caregivers in supportive communities practice optimal nutrition and care practices for children, with particular focus on recognizing and treating severe acute malnutrition.

The theory of change states that if caregivers and communities adopt optimal nutrition and care practices for children, then they will prevent and recognize malnutrition and demand services to address it.

3. CDSD Programme Outcomes in WASH

The CSD Programme rests on the premise is that if girls, boys and women have improved and equitable access to and utilize safe drinking water and sanitation services and practice improved hygiene behaviours, then the overall rate of WASH coverage in communities and institutions will increase and childhood mortality and malnutrition rates due to diarrhoea and related diseases will decrease.

The major bottlenecks in WASH are based on the 2012 bottleneck analysis and include the following (it is worth noting that some of the issues listed below, such as the approval of a sanitation policy, have already been resolved):

- Lack of accurate baseline data;
- Rural sanitation markets are largely undeveloped and there is a need for sanitation marketing;

- Lack of approved sanitation policy and national policy and operational policy in place to guide and develop overall sanitation programme in urban and peri-urban areas;
- Inadequate budgetary allocations;
- Limited human resources for WASH and CLTS in particular;
- Cultural and social norms;
- Limited knowledge and awareness on health, proper nutrition and hygiene practices at community and family levels;
- Very few development partners and donors present in the country which contributes to limited resource mobilization opportunities;
- Limited capacity of national and regional stakeholders to respond to natural and human-made disasters and epidemic diseases.

In line with the Government's sectoral priorities, the CSD programme includes two outcomes for WASH:

- Output 1: *National policies, effective financing, coordination and accountability for WASH, and local capacities for service delivery are strengthened, including during humanitarian situations.*

  The theory of change states that *if* at national level, the overall WASH system (polices, financing, coordination and accountability) is strengthened together with local capacities for service delivery and ties and accountability to communities, *then* children and women will benefit from improved water, sanitation and hygiene practices, with resulting improvements in health and well-being and girls' increased school attendance.

- Output 2: *National policies, effective financing, coordination and accountability for WASH, and local capacities for service delivery are strengthened, including during humanitarian situations.*

  The theory of change states that *if* caregivers and communities adopt adequate sanitation and hygiene practices, *then* the incidence of diarrhoea as a contributing factor to neonatal and under-5 mortality will decline. If public and private sector have the capacity to deliver equitable, sustainable and affordable WASH services, then there will be a WASH service that is continuously functional and of good quality.

The CSD programme is implemented at three levels: (a) at national level for the primary health care strategy revitalization and policies, DRR, and interventions such as immunization, salt iodization nutrition policies , guidelines and coordination, PMTCT, and emergency response; (b) at district level for the improvement of the health services and the delivery of high impact health and nutrition interventions; and (c) at community level for the C4D activities, support to primary health care with essential drugs and supplies and CLTS activities.

Overall, the CSD programme is contributing to following United Nations Development Assistance Framework (UNDAF) outcomes:

2.2 Increased equitable access to quality health care for all
Indicators: neonatal mortality rate; maternal mortality rate; availability of a national multi-sectoral action policy and plan to improve the management of and reduce non-communicable diseases and their risk factors; contraceptive prevalence rate.

2.3 Increased access to equitable water, sanitation and hygiene for all.
Indicators: proportion of population using improved water sources for drinking; proportion of population using improved sanitation facilities; proportion of population practicing open defecation.

2.4 Increased equitable and quality access to nutrition-specific and -sensitive services
Indicators: percentage of children under 5 years of age stunted; percentage of children under 5 years of age wasted; household dietary diversity score.

Given the visibility of the CSD programme and despite absorbing one third of the UNICEF resources in The Gambia Country Programme, the programme component has never undergone a formal external evaluation. Therefore, in order to get the most benefit of this evaluation, the greatest possible effort will be made to ensure that the overall exercise will generate relevant programmatic and operational learning not only for UNICEF but also for its other in-country partners.

2. Evaluation Purpose

This evaluation will have two purposes: accountability and learning.

This evaluation will provide both the donor (vertical accountability) and the expected beneficiaries (horizontal accountability) some solid evidence on the extent to which the CSD programme attained its envisaged objectives. This is more needed as the CSD programme takes up a third of the of the UNICEF overall portfolio in the country and it has never been evaluated.

With respect to learning, it is worth noting that the original expectation was for the findings of this major evaluation to feed into the design of both the UNICEF programme cycle (2017-2021) and the joint UN Development Assistance Framework (UNDAF) for 2017-20. In this context, the UNICEF CO in The Gambia worked to undertake the evaluation in 2016. However, as a qualified evaluator could not be recruited then, the evaluation was put on hold. Although the new Country programme 2017 – 2021 has already started, this evaluation is still greatly needed as it will not only inform the programme implementation strategies in the years to come (the current cycle will end in 2021) but it will also shed some light on some potential corrective actions that

may want to be explored further during the mid-term evaluation (due in mid-2019). In this vein, this evaluation, which was initially conceived as a summative evaluation, will also have a formative nature

More specifically, this evaluation is expected to generate recommendations that will help UNICEF Gambia CSD programme staff as well as other in-country partners (see table below) to adapt the implementation of the CSD Programme (2017-2021) to the emerging and country-specific needs in this area. For instance, the evaluation will seek to come up with recommendations on how the CSD programme could:

- enhance equitable access to basic health services for the most disadvantaged children;
- strengthen community interventions to tackle emerging epidemics like Ebola; and
- combat deadly childhood illnesses such as malaria and diarrhoeas through promotion of key household behaviours and CLTS.

Evaluation Users	Evaluation Uses
UNICEF CSD Section Staff	By better understanding the contributions of the integrated CSD section to The Gambia's developmental agenda, UNICEF will amend their CSD Programme Strategy, in concurrent with mid-term review of the UNICEF country programme in 2019.
UNICEF Sections Staff	The corresponding use would be "to define a better coordination strategy with CSD towards the attainment of the different CSD outcomes" and "to identify the concrete modalities of strategic collaboration towards the attainment of (including KRCs)
UN and other developmental partners (H4 Plus)	The CSD Section, in collaboration with all other partners involved in the implementation of the UN Development Assistance Framework (UNDAF), will introduce strategic/implementations changes to their strategy for 2021 onwards..\..\..\UNDAF\Copy of UN Gambia consolidated costed work plan with activities for Youth and Gender 170418 (003).xlsx
Government (Health and other line ministries)	Will better define the terms of collaboration with UNICEF with respect to the attainment of the relevant goals set in the National Development Plan (NDP)..\..\..\AWP\NDP\The Gambia National Development Plan (NDP) 2018 - 2021 Popular Version Final.pdf
NGOs/CBOs	Mainstream (into their day-to-day practices) the good practices identified during the

	evaluation and address the weaknesses emerged in the course of the analysis

3. Evaluation Objectives

The Objectives of the Evaluation are:

1. To determine the relevance, efficiency, effectiveness, impact and sustainability of the CSD programme in supporting Government to reach the vulnerable women and children to access and use quality health services, including nutrition, immunization, MCH, PMTCT and WASH services;

2. To identify lessons learned about what worked and did not work about the CSD programmes, including unexpected outcomes (positive and negative);

3. To formulate key recommendations on how to improve the implementation processes and performance of the different projects implemented as part of continual learning process;

4. To assess the extent to which the CSD programme has integrated equity and gender in its design, implementation and monitoring.

4. Evaluation Scope

Thematic Scope: the evaluation will gauge the vulnerable women's and children's access and use of interventions in many areas, namely health, nutrition, WASH and HIV (including PTMCT).

The evaluation will focus on the following:

a) At the National level, the extent to which the Programme has contributed to the following: policy and guideline development, coordination, immunization coverage, and disaster risk reduction; and will determine how all of the above has contributed to the achievement of the SDGs as well as to addressing inequities (social, geographical and financial);
b) At the sub-national level, the extent to which the Programme had contributed to the following ensuring that the health facilities and personnel are equipped with skills and supplies to effectively deliver high impact health and nutrition interventions will be assessed;
c) At the community level, the extent to which community-focused interventions, such as the Community Lead Total Sanitation (CLTS) and the Communications for Development (C4D) Programme components contributed to the reduction of

childhood diseases, such as diarrhoea and malaria, as well as to the adoption of key essential family practices and behaviours.

d) Availability of supplies and the role of community structures to support CSD implementation Multi-Disciplinary Facilitation Teams (MDFTs); Village Development Committees (VDC) etc. in promoting key household behaviours

e)

Geographical Scope: the desk review to be conducted as part of this evaluation is expected to cover all the activities implemented as part of the CSD programme nationwide. However, the data collection will concentrate on a smaller sample of intervention sites.

Chronological Scope: As the new Country Programme Cycle has already started, the evaluation will make sure to capture the essence of the CSD strategies included in the new Country Programme Cycle (January 1st 2017 to December 31st 2021) *so* as to make more relevant and better targeted recommendations.

5. Evaluation Context

The GoTG - UNICEF Mid-Term Review (MTR) of the Country Programme 2012-2016 was conducted in 2014 and the CSD Programme was reviewed with partners. Notable achievements were registered in the Programme and the constraints and the opportunities were identified. The review also took into consideration the changing environment in the region particularly the threat of epidemics (EVD) and the post-2015 agenda. The Organization's strategies and vision was also taken into consideration such as *A Promise Renewed*, the SUN movement and the new UNICEF Strategic Plan 2014-2017.

No further evaluation or assessment of the contribution to and impact of CSD programme on the developmental perspective has been conducted to date.

6. Evaluation Criteria

This evaluation will be guided by six criteria: the five OECD criteria (Relevance, Effectiveness, Efficiency, Impact and Sustainability) and an additional Gender and Human Rights criteria..\OECD DAC Evaluation Criteria.pdf

7. Evaluation questions

The Evaluation will seek to answer the following questions:

1. Relevance:

1.1. To what extent are the new CSD Programme's interventions relevant to the Government's priorities?

1.2. To what extent does the CSD programme respond to the identified (?) needs of its expected beneficiaries?

1.3. How complementary are the UNICEF's CSD interventions with those implemented by the other partners and governments to reach the most vulnerable?
1.4. How aligned is the new UNICEF's CSD programme to the existing support in WASH, Health and Nutrition sectors?

2. Effectiveness:
2.1. To what extent did the CSD programme achieve its intended objectives?
2.2. To what extent did UNICEF-supported activities ensure that the most vulnerable children and women have access to basic health services?
2.3. To what extent did care-givers are practising the Kangaroo Care Health Practices (KCHPs) to reduce child illnesses;
2.4. To what extent were Immunisation services and nutrition services related with Management of severe malnutrition and CLTS approach within the context of ODF agenda?
2.5. What are the factors (internal and external to UNICEF) that contributed the most to the success of the CSD Programme?
2.6. What are the factors (internal and external to UNICEF) that hindered the most the success of the CSD Programme?
2.7. What are the unexpected outcomes (positive and negative) produced by the CSD Programme?
2.8. To what extent did strategic partners and partnerships contribute to the attainment of the CSD programme results?

3.Efficiency:
3.1. Were there other alternative strategies that could have been put in place to achieve the same level of result but at a lesser cost?
3.2. To what extent were financial resources, human resources and supplies:
-sufficient (quantity)?
-adequate (quality)?
-distributed/deployed in a timely manner?

3.3. To what extent did the partnerships help keep down the costs of programme delivery?

4.Impact
4.1. To what extent has the UNICEF CSD programme contributed to the reduction of childhood illnesses and child mortality?

5. Sustainability:
5.1. How did UNICEF incorporate measures for the community-based interventions, such as the CLTS and C4D, to be continued without UNICEF support after the completion of the Country Programme in 2021?
5.2. For those 'high investment' interventions, such as procurement of supplies and drugs as well as vaccination campaigns, what procedures (if any) were put in in place for the Government of The Gambia to accrue funding of these expenditures?
5.3. To what extent were the CSD programme activities replicated by government and other partners?

6. Gender and human rights, equity

6.1. To what extent were Gender, Human rights and Equity principles duly integrated in the design and delivery of the programme?

6.2. To what extent did the CSD programme tackle the barriers that prevents' girls and women's access to the services that it made available in the targeted communities?

8. Evaluation Methodology

The evaluation will be based on mixed methods approach. This could, among others, including the following:

- A quantitative analysis of existing data such as the MICS, DHS, Health Management information system, the National Health Sector Strategic Plan, SMART surveys, existing monitoring data, etc.
- Qualitative methods including but not limited to the following:
  - Key Informant Interviews;
  - Focus Group Discussions;
  - Structured and semi-structured interviews;
  - Desk Review;
  - Facilities and community structure inspection.
- A desk review of all the documents such as the UNDAF, UNICEF CPD, etc.

A detailed design of the evaluation including the proposed methodology for each evaluation question and/or objectives, sample size, sampling methodology and the tools to be used will be proposed by the consultant in his/her bid and agreed to by a technical steering committee. **The consultants are strongly encouraged to propose the use of innovative methodologies in their technical proposal.**

The Evaluation will cover the implementation of the entire CSD programme, including at the community level. The consultant is expected to take field trips to the programme intervention areas to ascertain the contribution of the programme and to solicit beneficiary perspectives.

9. Schedule of Tasks, Deliverables, Duty-Station & Timeline

The consultancy will be three months in duration and will consist of three main phases:

Activity
Phase 1
Development of inception report (this will include the development of the evaluation design and the data collection tools) + Inception Meetings
Phase II
Data collection and Field work + Debriefing on preliminary findings

Phase III
Data analysis, report writing (draft and final), validation and dissemination

Deliverables:

1) Inception Report, including a detailed description of the methodology, data collection tools, and suggested work plan;
2) Power Point summarizing key preliminary findings and conclusions (to be held before the international consultant leaves the country);
3) First draft of the evaluation report;
4) Final Evaluation report (max 50 pages with the rest to be placed in annexes) incorporating the commented made by UNICEF staff and the Reference Group members;
5) Power Point Presentation which summarizes the Evaluation Report with slide(s) of Key findings and recommendations;
6) Raw data in electronic medium, data collection instruments in electronic medium, transcripts in electronic medium, completed data sets, etc.

The contractor will need to make sure that the draft report and final report will be consistent with the international evaluation quality standards namely: the UNEG Checklist on Quality Evaluation Reports[115] and the GEROS Quality Assessment Criteria[116].

Duty-Station

The Consultant will be based in The Gambia during the primary data collection phase and will work remotely (in his/her home country) during the rest of the assignment when physical presence in the country is not required. This will be proposed by the Consultant in the bid document and discussed and agreed between the UNICEF and the Consultant.

10. Governance of the evaluation

The contractor will be supervised and report to the UNICEF CO Deputy Representative as s/he would be assessing the CSD sections performance and achievements so it is logical top place him outside the section. The contractor will work on a daily basis and in close collaboration with the UNICEF Country Office M&E officer who reports to the Deputy Representative. For the sake of transparency and in order to enhance the independence of the evaluation, the Deputy Representative will make sure to copy the M&E Officer on all email correspondence with the contractor. A steering committee comprising of Government and UNICEF officers will be set up to provide oversight to the Evaluation and provide comments. The Regional Evaluation Adviser based at the UNICEF Regional Office for West and Central Africa (WCARO) will also provide technical oversight over the entire evaluation process, including on the different evaluation products (inception report, draft and evaluation report).

[115] https://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/about_iom/eva_techref/UNEG_Eval_Report.pdf

[116] https://www.unicef.org/evaluation/files/GEROS_Methodology_v7.pdf

BIO-DATA OF THE CONSULTANT

Mrs. Lotta Nycander is a Swedish national born in 1954, residing in Sweden. She is a senior consultant (evaluator) with a background in Social Anthropology and thirty-four years of experience from project management, planning and design of programmes, and evaluation. She has carried out more than thirty independent evaluations, and as well as and many reviews and assessments of international programs and projects for UN agencies.

Between 1985 and 2004, she worked as a lead researcher/trainer, expert, team leader, project manager, chief technical adviser and senior adviser in programmes focused on social and economic development. Since 2004 she has worked independently as a consultant through her own firm Social Resources Management (SRM) Ltd.

The organisations she has worked for are UNICEF, ILO, UN-HABITAT, FAO, UNDP, UN Environment and projects funded by UNCTAD, ITC, AfDB, KfW, EU, IPU and many bilateral agencies including the Swedish International Development Cooperation Agency (Sida).

Her field of work includes employment, inclusive growth, social protection, elimination of child labour, forced labour and trafficking in countries in East, West and Southern Africa, South, South-East and Central Asia and Eastern Europe. Human rights, equity and equality issues – in particular gender equality are strong themes in all her work in the context of social and economic policy of the developing economies.

She has also worked for a number of years with policies related to working conditions including child labour, and productivity in agriculture including soil and conservation, flood protection and the cotton industry, water and sanitation for rural and urban vulnerable populations, cash transfer and micro health insurance within health programs.

ANNEX II. DATA COLLECTION TOOLS (INTERVIEW GUIDES) IN INTERVIEWS AND FOCUSED DISCUSSIONS

Relevant ministries (MoH and MoFWR) at national level

1. What is the core objectives of your (program, department)?
2. How many staff members are working in your (program, department) and how many are women?
3. How is the situation regarding staff movements (change of staff on key positions)?
4. In which way are you/your program/department cooperating with UNICEF-CSD program?
5. To what extent have you participated in training or other events organised through the CSD program, or PIC program?
6. How long have you been working in the (division, department, position)?
7. How well are you acquainted with the CDS and PIC UNICEF programs?
8. Do you have any knowledge, or can you recall the CDS program all the way back to 2012?
9. If you are familiar with the previous program - what are the key differences between before 2016 and after 2016?
10. Do you have any documents to share that are relevant to your involvement with UNICEF-CSD?
11. Are you aware of the MICS results from 2018? Do you have any comment on the survey or the results?
12. What positive/negative aspects regarding your cooperation with CDS program can you share (*this relates to technical assistance, planning, implementation, follow-up, field assessments, funding, resources, study tours, training and more*)?
13. Is there anything you are not satisfied with regarding CDS program, or UNICEF; and that you think could be improved, and if so, what?
14. What other development partner (international organisations, donor agencies) are supporting your (unit)?
15. Is there anything you would like to bring to the attention of CSD, through the evaluation?
16. What is your vision for the future?

Health and nutrition centres (sub-national areas)

17. What is your role (in the organisation, team, committee)?
18. How do you work with your colleagues? (routines, procedures)
19. Which are the most common diseases and ailments of children under 5 years, and what are the common diseases and ailments of their mothers? And young girls/adolescents?
20. To what extent is your stock of medicines adequate? If not adequate, what is the reason?
21. Could you please explain (or show me) the existing water and sanitation facilities? What are the main problems related to water supply and toilets? How have you been able to overcome these or what do you intend to do about them?
22. How do you perceive the adequacy and timeliness regarding funds (operational), access to resources, tools, machines, vaccines, cold storage (and more) received from the (national level);

23. What, according to your knowledge, is the progress in your area in terms of the health and nutrition situation among children (U5 particularly) and their mothers/caretakers
24. What, according to your knowledge, and perception are the key differences in terms of health and nutrition status, access to health care including vaccinations, referrals to hospitals and emergency care, behaviour of caretakers including health seeking behaviour (and more) between earlier periods (earlier program period) and today?
25. How do you see development/progress in the areas that CSD program is working on (child survival and development: MCH, HIV, nutrition, PMTCT, essential care and health seeking behaviour)?
26. Are there any particular issues in your work with the clients/patients regarding women, mothers, adolescent, children, neonatal (gender issues)? Are there any specific issues that relate to men, fathers and boys?
27. How is the centre/ward able to provide safe environments for women/girls giving birth? What problems and complications are you and the women/children facing if they are delivered in your centre? What have you done in order to improve the situation if not satisfactory?
28. How does your centre serve clients/patients/children who have no documents/no registration and those coming from other countries?
29. How does your centre treat children and/or mothers with disabilities?
30. To what extent does your position allow you to make decisions regarding your day to day operations/work – and other "larger" decisions that affect your work situation?
31. To what extent has the level of your ability to make decisions (as above) been changed over the years (going back to 2012)?
32. What (if any) programmes/projects are implemented with your involvement?
33. What other programmes exist in (this area) which in some way may have affected your ability to serve your clients/patients? Please describe (types of activities, approaches, funding).
34. To what extent are environmental issues have an impact on your work?
35. Which areas and which vulnerable populations/villages/children/mothers are you not able to serve and what are the reasons? Are you aware of any plans to reach others – more effectively? What is your perception of these plans and are you involved in any way in discussions on these issues?
36. What is the role of your activities/your centre in relation to the other actors in the health sector structure? (district, village, community)
37. Which are the main challenges and difficulties that you face in performing your duties?
38. What training or other staff support activities have you been able to participate in?
39. According to your knowledge what is the contribution of UNICEF and CDD program to your work – and overall in the country?

Questions VDCs, Multi-purpose teams (Extension officers), VSG, Village Health Workers, CBCs

40. To what extent - and in which way - are you involved in supporting health care, nutrient supply and/or other activities related to children´s health and development (including neo-natals and their mothers/caregivers)?

41. How do you and your (unit) work together with other institutions to serve families living in poverty, and who need healthcare or support in connection with giving birth or caring for neo-natals?
42. What (if any) preventive measures are you taking (or your unit) to support mothers and children in the area of health and nutrition?
43. To what extent have you been participating in training events organised by the MoH or UNICEF (skills- and capacity development or other)?
44. What other programmes/projects (if any) are being implemented in (your area? Do you know anything about how they affect (impact) women and children in your "catchment area (circuit)"?
45. Are you aware of any activities that UNICEF has been involved with? What is your perception of these (if any) and what effects they may have had?
46. Is there any message you want me to bring to the higher authorities in connection with (CDS areas)?

Questions to schools/madrasas/LBS and pupils

47. What is the situation regarding water and sanitation and in your students'/pupils´ access to quality water?
48. What is the situation regarding sanitation (toilets), please show me? Are there specific for girls and boys, and teachers? If not, why not?
49. If water is not available, what have you done to improve the situation? How did you succeed? If not, what are the remaining problems?
50. Are you aware of any consequences for young girls if the standard and situation of specifically for girls is not good (not clean, no access to sanitary pads)?
51. Are the VIP latrines (UNICEF constructed or others) kept looked or open for students? If looked, why? How do girls get access to toilets if they are looked? Who keeps the key?
52. Do your children get anything to eat during school days? What do they get?
53. What are the subjects taught in the school? What is the proportion of girls and boys
54. Are there any female teachers or female staff working here? What is the proportion women/men?

Questions used in villagers (women, men, adolescents, girls, boys, village heads)

55. What is the situation regarding existence, access and types of water supply?
56. What is the situation regarding existence, access and types of sanitation/toilets (pit latrines, VIP latrines or other?) in this village?
57. If not common to have toilets (or latrines) in the households or compounds - what are the reasons and what is done to improve the situation?
58. Has anyone (from outside) been here to talk to you about water and sanitation?
59. Have you taken part in a CTLS; or do you know anyone who has?
60. Has anyone in this village organised or mobilised others to help improve the (WaSH) situation?
61. If young people are not available to help digging for latrines – what are you going to do?
62. Are you aware of any health risks for small children when there are no latrines nearby the houses (compounds)?
63. If you are aware, what do you think should be done about it?
64. What are the effects on the stability of the latrines when the rain comes?

65. Who should be responsible to dig pits for latrines, or help construct latrines?
66. What do you do when latrines are breaking down (e.g. due to rains/flooding) ?
67. Do all households in the compound use the Latrine, and if not where do they go? Can you show me where they go?
68. Are there different toilets for girls and boys?
69. If water is not available, what have you done to improve the situation? How did you succeed? If not, what are the remaining problems?
70. When women give birth – do they give birth in the village or in a health centre? Do women (you) prefer giving birth at home or in a hospital/clinic? If going to a clinic what are the risks and what are the advantages?
71. How often do you (women) visit a health centre? Which one (distance)?
72. What role does the CBC play at the time of giving birth?

Questions to UN agencies and international organisations

73. What is your role vis-a´-vis the Government and its NDP and with the ministries and that UNICEF supporting (MoH and MOFWR)?
74. To what extent are you aware of UNICEF´s programs in The Gambia, and the CSD program?
75. What are your linkages (or partnership/cooperation depending on what seems most feasible for the agency)?
76. How are you in contact with CSD manager and/or staff?
77. What is your knowledge, or perception of CSD-UNICEF´s achievements and possible lack of achievements specifically at policy level, in the areas of MCH including HIV and immunization, behaviour change and caring for new mothers and neonatal children, nutrition and WaSH?
78. Are you or your staff involved in any field assessment, or other monitoring field visits in which UNICEF-CSD also is represented?
79. To what extent is the partnership functioning well?
80. If there are any challenges, what are they and how are you trying to overcome them?
81. In which meetings or platforms do you discuss yours, and other UN agencies´ goals and how often are they held?
82. Are there any policies or action plans that you are currently working on within the framework of partnership with the Government?
83. How often and in which type of high-level meetings are you able to bring up policy issues and implementation issues with the Government/ministries?
84. Is your agency commissioning work to NGOs and CBS, and which are they? What are the benefits and disadvantages and are there any risks associated with this cooperation?

ANNEX III. PRELIMINARY FINDINGS PRESENTED IN THE VALIDATION MEETING

The following is the text presented through a PPT presentation, on the preliminary findings, in the Validation Meeting at UNICEF on 16 June 2019:

1. What is guiding UNICEF in The Gambia?

UNDAF outcomes for health

- increased equitable access to quality health for all
- increased equitable access to quality water, sanitation and hygiene for all
- Increased equitable access to quality nutrition-specific services for all; and
- Access to integrated, inclusive and sustainable social protection services for vulnerable groups (social inclusion).

Important also:

National Development Plan 2017-2022 and related national policies; and

CRC (Convention on the Rights of the Child) - the concluding observations.

2. Two program components

Protection and Inclusion of Children - Supports the Government of The Gambia to have a child protection system that responds to violence, abuse & exploitation of children, early childhood education to all children, & rights of children to get a quality education.

Child Survival and Development (object of the evaluation) - Supports the Government of The Gambia to reach vulnerable women and children to better access and use quality health services: nutrition, immunization, maternal & child health, prevention of mother-to-child transmission of HIV, and services in water, sanitation and hygiene. Contributes to strengthening of health systems through capacity-building and service delivery.

CSD Team: Nine persons plus three officials that work for both programs on Communication for Development (C4D) and monitoring and evaluation.

5. CSD Outcomes to contribute to

Health outcomes

- A strengthened PHC system that provides equitable and quality maternal and child health services for all girls, boys and women (Output 1)
- Communities acquire positive behaviour and demonstrate enhanced demand for health services, with particular focus on the neonatal period; and (Output 2)
- Community-level capacities are strengthened to deliver quality maternal and child health services (Output 3)

Nutrition outcomes

- A national nutrition system is strengthened with capacities to respond to shocks and meet community needs in providing equitable and quality nutrition services; and (Output 1)
- Caregivers in supported communities practice optimal nutrition and care practices for children, with particular focus on recognizing and treating severe acute malnutrition (Output 2)

Water and sanitation, and hygiene (WaSH) outcomes

- National policies, effective financing, coordination and accountability for WaSH, and local capacities for service delivery are strengthened, including during humanitarian situations (Output 1)
- Caregivers and communities use safe drinking water and adopt adequate sanitation and good hygiene practices (Output 2)

6. What is the logic behind change (health outcome)

If children and women have access to and utilize improved and equitable quality maternal and child health services and learn and practise healthy behaviours..

..then - children will benefit from immunization and other preventive services, childhood diseases will be recognized and treated appropriately and maternal, neonatal and child mortality will be reduced.

7. What is the logic behind change (Nutrition outcome)

If all children, adolescent girls and women, especially the most vulnerable, realize their rights and utilize equitable and quality nutrition services and care practices…

..then - the rates of stunting, wasting and micronutrient deficiencies will decline, especially among children in the first 1,000 days of life; children with severe acute malnutrition will be treated appropriately; and under-five mortality will be reduced.

8. What is the logic behind change change (WASH outcome)?

If girls, boys and women have improved and equitable access to and utilize safe drinking water and sanitation services and practise improved hygiene behaviours..

..then - childhood mortality and malnutrition rates due to diarrhoea and related diseases will decrease

9. Strategies

- Policy advocacy – "upstream"
- Providing technical support to key stakeholders in country
- Supporting community-based systems and services - "downstream"
- Collaboration and coordination across sectors (intersectoral) at the community level

10. Purpose of the evaluation

An evaluation was supposed to be done in 2015 (not done). UNICEF has defined this evaluation is as :

- Formative –to inform on potential corrective actions of 2017-2021 ongoing program (to be further explored also by MTE end 2019) – and
- Summative - as it will determine the extent of achievement of the outcomes during the previous cycle (2012-2016)

Purposes: Accountability in CSD reaching its outcomes - and Learning to better adapt to needs of the country (results feed into a MTR at end 2019).

Users (Stakeholders): UNICEF, MoH, MoFWR, MWACSW, NaNA UNFPA, WFP, UNAIDS, FAO, Red Cross and HePDO

Potential Uses: Inform the application of quality policies, planning and practices related to the following:

- health, nutrition, water and sanitation, and hygiene

- food and nutrition response in emergencies
- sexual and reproductive health and rights, HIV/Aids,
- gender-responsive and inclusive policies – and planning & follow-up

11. Meaning of evaluation criteria

Relevance - extent to which CSD program is in line with the priorities and policies of the national development agenda and key stakeholders as well as the (direct, indirect, ultimate) program participants (also called "beneficiaries") as well as UNICEF itself

Effectiveness - extent to which strategies and activities contribute to meeting the stated CSD-UNICEF key outcomes

Efficiency - whether the least costly resources possible were used to reach the intended results

Impact - any key positive and negative changes generated through the implementation of the CSD program (directly or indirectly, intended or unintended)

Sustainability - whether the benefits accrued are likely to be continued and sustained after the end of UNICEF´s current Country Program (2017-2019) support

12. Objectives of the CSD evaluaton

Determine the relevance, efficiency, effectiveness, impact and sustainability

Identify what worked and what did not? what lessons have been learned?

Assess how CSD has integrated equity and gender in its design, implementation and monitoring

Formulate recommendations on how to improve the implementation processes and performance

13. Scope of the evaluation

Thematic scope

Extent of contribution to policy & guideline development, coordination, immunization and disaster risk reduction and reaching SDGs? (national level);

Extent of health facilities and staff being equipped with skills and supplies (sub-national level)

Extent of reduction of childhood diseases, availability of supplies, multi-disciplinary teams & village development committees promote key household behaviours (community level)

Geographical scope: Country- but focus on Lower River Region (LRR), Central River Region CRR) and Upper River Region (URR).

Chronological scope: CSD current and earlier strategies 2012-16 Country Program

14. Evaluation methodology

- Comprehensive review of relevant documentation
- Semi-structured in-depth interviews
- Focused discussions
- Survey (small questionnaires)
- Observation in the field
- Quality Assurance/Triangulation

Field visits (LRR, CRR, URR).

Both quantitative and qualitative data has been collected.

To date, more than 80 people have participated in the evaluation process, in interviews and focused discussions. MoH, MoWR, NaNA and 6 UN agencies have participated in the process.

15. Preliminary Findings

Relevance

CSD program is relevant in terms of being in line with the National Development Plan and UNDAF. (UNICEF is leading the UNDAF outcome on Human Capital areas: (education (1), health (2), social protection (3) Gender and youth (4).)

CSD´s three work areas are clear vis-à-vis the stakeholders – i.e. complementing other UN agencies (WFP, UNFPA, UNAIDS, WHO, FAO), WB and NaNA in supporting the government.

Relevance for children and women in villages and communities could be higher if the Government prioritized MCH and development issues in vulnerable areas – and if suitable non-government actors were more involved at community level.

16. Relevance (continued)

Comparison old and new CSD program "design"

New one is more subject-specific compared to 2012-2016

Health, Nutrition and Wash given separate outcomes in new program.

Earlier program had two only result areas: 1) Health, PMTCT, nutrition and Wash lumped together and 2) one outcome on "adopted essential care practices".

Earlier program focused only on CRR, URR and NBE – new program is nationwide and "can pick" areas where UNICEF can make highest impact and where needs are, including urban western areas.

New emphasis in the new program:

- In Health: Utilization (of resources, not just access), equity and behaviours
- In Nutrition: Rights issue
- In Wash: Utilization

17. Problems impacting on high maternal and newborn morbidity and mortality (identified in by UNDAF RG2 Health outcome team in "problem tree" exercise)

- Inadequate access to basic health services
- Low contraceptive prevalence rate
- High malnutrition rate, stunting and wasting
- Inadequate institutional capacity for implementation of WASH services
- Inadequate access to sanitation services
- Lack of health insurance scheme
- Low access to skilled birth attendants
- Inadequate access to Basic emergency obstetrics and newborn care (BEMOC) and Comprehensive emergency obstetrics and newborn care (CEmOC) services, including postnatal care
- High burden of non-communicable disease
- High staff attrition rate
- Inadequate access to safe drinking water

- Inadequate access to Basic and Comprehensive Emergengecy Obstetric and New born Care Services *(this is a prioritized problem)*

18. Recent figures: child mortality

Main causes of childhood mortality and morbidity

- Malaria for under-fives and respiratory infections and pneumonia, diarrhoeal disease, malnutrition and sepsis in neonates – all preventable and treatable.
- During the last decade under-five mortality rates declined
- Has declined from 61/1000 live births to 57 deaths per 1000 born (boys 64 – girls 50)
- Urban-rural divide: 53 deaths per 1000 born in urban and 64 deaths per 1000 born in rural
- (Kantuar LGA has the highest mortality at 77/1000 live births (MICS 2018)
- But during the last 5 years - neonatal mortality rates have been on the rise
- The number of neonates dying before reaching 28 days of age, has increased from 28 to 31/1000 live births (higher for boys: 35, and for girls: 26) Kuntaur LGA: 38/1000 and Brikama (urban) LGA 35/1000 live births).
- Urban areas has slightly higher rates of neo-natal mortality than rural areas
- Exception regarding the urban-rural divide: 32 in urban and 28 in rural.

19. Recent figures: Stunting, wasting

- Prevalence of stunting in children 0-59 months reduced
- Has reduced from 23% to 15.7%. Stunting of children is almost double as frequent in rural areas (15.9%) than among children in urban areas (7.8%). Kuntaur having highest 21.3% levels of stunting as compared to Banjul (6.9%)
- Prevalence of wasting in 0-59 months old children also reduced
- Has reduced from 10% to 6%. Rural children are more wasted, almost double - 6.2% compared to 3.6% in urban.
- More than half of Gambian children are anemic
- (hemoglobin <110 g/L). Prevalence is higher for rural children (57%) and boys (54%) as compared to urban (46%) and girls (45%); and
- Nationally, 18.2% of children have Vitamin A deficiency.

20. Recent figures: Water, sanitation and hygiene

- Majority of households (85%) have access to basic drinking water services. Figures are 2018.
- Access to basic drinking water services has improved - BUT still - 34% are using safely managed drinking water services. Disparities continue between urban (90%) and rural (73%). E.g. Kuntaur: 66% have access basic drinking water services compared to Banjul: 100%;
- Vast majority (99%) of households are open defecation free (ODF) and 62% have access to improved Sanitation.
- BUT 3000 households in 127 communities in CRR North are not ODF and here 82% practice open defecation (new survey).

- Only one third (31%) of the household population have hand washing facility with water and soap which is still very low; and
- 73% of households are at risk of faecal contamination of drinking water based on number of E. coli detected. The situation is worse for rural areas (92%)

21. Preliminary findings on CSD-UNICEF contributions

- Policy development and strategic plans (previous and current program periods)
- Capacity development and service delivery
- Issues high on CSD´s agenda for the coming two years

22. Policy development - Health

(previous and current programme cycle)

- Health sector bottleneck analysis 2014 and investment plan for health
- Bottleneck analysis on the Prevention of Mother to Child Transmission (PMTCT) 2014
- Policy and strategic plan to reduce Malaria 2014-2020.
- Reproductive Maternal New born Child and Adolescent Health policy (2017-2026) and strategic plan (2017-2022)
- National Policy and Strategic plan on Viral Hepatitis (2017-2022)
- Roadmap for Revitalizing and Scaling-up of Primary Health Care

23. Policy development – nutrition

Previous program 2012-2016

- Nutrition bottleneck analysis 2017
- Recommendations from this study was used in the updating and reviewing the National Nutrition Policy and development of new nutrition strategy to address key supply, demand and quality related bottlenecks at national and regional levels.
- Integrated Management of Acute Malnutrition (IMAM)
- UNICEF has supported improved care of management in 112 out of 165 health facilities across the country, representing 68% geographic coverage.

24. Policy development - Wash

(previous programme cycle)

- Sanitation bottleneck analysis 2014
- Ministers´ commitment to eliminate OD by 2015
- WASH bottleneck analysis 2017 and WASH action plan
- recommendations from the analysis were used for advocacy and informed the development of 2017 annual work plans of the WASH sector
- National Sanitation Policy 2017
- was adopted and approved by the Cabinet in February, 2016
- National Open Defecation Free (ODF) Action Plan, 2017
- was finalised and shared with stakeholders at national and regional level

25. Key activities 2012-2016

Health

- Bottleneck analysis and Investment plan
- Drugs and supplies to MoH (for URR and CRR especially) to 228 PHC villages, benefitted 4,762 children
- High immunization coverage rates (Polio, Measles and TT2) & new vaccines introduced yearly.

Nutrition

- IMAM protocol (management of acute malnutrition) endorsed by MoH
- SMART nutrition survey
- Bottleneck analysis on the Prevention of Mother to Child Transition (PMTCT) with follow-up plan (resources mobilisation).

WaSH

- Open defecation rates dropped from 5.1% in 2010 to 3.5 % in rural areas in 2013 (MICS 2010 and DHS 2013) (Kuntaur and Janjanbureh were among the most vulnerable areas with the highest under-five mortality rate registered the highest rate of open defecation).
- Services delivered, utilized and maintained in 200 PIQSS schools and selected communities in the 20 targeted districts.
- A total of 20,685 pupils and 46% of the 200 targeted schools got access to functional improved water and sanitation facilities.
- Sanitation bottleneck analysis and ministerial commitment was made to eliminate open defecation by 2015. Monitoring was done on effects of the (2009) training on CLTS (which targeted communities in West Coast Regions, particularly along the Gambia – Casamance Border, Central River, Upper River, and Lower River Regions further reducing ODF.

26. Key activities - health (2017-2021)

Capacity development

At end 2018 48 Health Workers had been trained to manage complications (maternal, newborn, childhood illnesses); 50 Village Health Workers trained in order to decrease referrals to health facilities/clinics; 120 professionals trained on Baby-friendly hospital Initiatives (with NaNA).

Service provision

- Implementing the Integrated Management of Acute Malnutrition (IMAM) program - jointly with WFP, NaNA and MoH (and training of staff).
- Treatment of Severe and Acute Malnutrition (SAM) (UNICEF sole agency): In 2018, total admitted: 3434; 84,3% cured. In 2017 total admitted was 5793, 88,3% cured.
- Protection from disease through immunization (EPI) (is grant manager for GAVI) resulting in high rates: 94% of DTP3 . Being 4 % above the target.
- Improving cold chain capacity for vaccines (81% of facilities have).

27. Key activities – health (2017-2021) continued

- Improving the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) system;
- Assessment of health clinics on maternal and newborn care;

- Strengthening the Nsaa Kenno initiative to view Village Development Committee as the centre at sub-national level;
- Implementing the Integrated Community Case Management (ICCM) - to support community health workers in providing services;
- Birth registration of 6, 000 children (BReST) (PIC activity) & social cash transfers to mothers
- Undertaking TV and radio broadcasting on breastfeeding; Oriented 300 Village Support Groups (VSG) – who in turn counselled 18,000 mothers.
- Supplying Vitamin A and deworming (health centers)

28. Key activites - nutrition (2017-2021)

Acute malnutrition and stunting have gradually increased in past two decades. UNICEF-CSD supported the government and worked with NaNA and MoH with the following:

- Micro-nutrient study to assess the status of deficiencies among women and children - final report 2019 (recent study)
- New strategy on social behaviour communication and change
- Review of the National Nutrition Policy 2010-2020
- Provision of life saving nutrition supplies
- Working closely with NaNA on surveillance of quality data monitoring
- Rehabilitating some water structures in villages and in Kuntaur Health Centre.

29. Key activites - WaSH (2017-2021)

Monitoring Open Defecation Free (ODF) situation in 19 districts (in follow up on 2016 activities)

Now the country is almost 99% ODF – BUT much more needs to be done to make the country completely ODF

Produced Guideline for WaSH (to be finalised)

Provided WaSH facilities in 51 schools

Planning for renewed CTLS activities in a number of villages first half of 2019

30. More findings

- Good efforts made to contribute to coordination in terms of planning, capacity development, joint assessments/monitoring (MOH, UN)
- Good efforts made in using the available structure: Regional Health Teams, Village Development Teams, Multi-Disciplinary Facilitation Teams and volunteers.

BUT..

- MoH Directorates´ financial system is not well functioning;
- There are overlaps/duplication of efforts within MOH (PHC unit, RPH unit, and CH unit);
- At regional level (RHCs) resources are scarce and received late in the year making planning for activities difficult at sub-national level (by end of first quarter of the F/Y 2019, RHCs had not received funds).

31. More findings

The health care system is not able to reach and serve the ”Non-PHC villages”

(It appears that) no gender analysis has been done in this or previous program specifically related to CSD program.

Working together within UNICEF CO (CSO and PIC) has improved – e.g. through the Nsaa Kenno concept - but could be further improved

GoTG needs to prioritize Maternal and Child Health, Nutrition and WaSH

32. High on the agenda for CSD the coming two years

1) *ODF - Ensure there is integration to reach ODF goals*

- 3000 households are ODF – scattered n 127 communities. Resources are needed to find out the reasons.
- Renewed commitment necessary from the highest level is needed.
- Plans under way to step up Community Total Led Sanitation training in 2019.

2*) Reduce neonatal mortality*

A research study will be carried out to enquire what can be done – but funds need to be solicited.

34. High on the agenda for CSD the coming two years (continued)

3) *Addressing the issues of pneumonia*

To be treated through integrated care management. This is a project to be carried out, with the support from Headquarters and RO. Related issues to address are malnutrition and infectious diseases.

4) Birth registration this year and next year

(child protection section - PIC). This is part of MoH´s mandate. Currently BR is at 52-53 percent.

5) Address Anaemia

through Vitamin A - critical

6) Immunization rate should continue to be high and be even higher

35**. Remaining**

- More analysis to be done for efficiency (CO HACT)
- Small questionnaire for the CO staff to be done this week
- Analysis of data regarding impact and sustainability
- Draft evaluation report & collect written comments
- Final report (addressing comments) with conclusions and recommendations

2017-2021 program period

These were identified as the challenges in the process of developing the recent UN Development Framework (UNDAF), in which CSD Manager participated:

- Inadequate access to basic health services;
- Low contraceptive prevalence rate;
- High malnutrition rate, stunting and wasting ;
- Inadequate institutional capacity for implementation of WASH services;
- Inadequate access to sanitation services;
- Lack of health insurance scheme;
- Low access to skilled birth attendants;

- Inadequate access to Basic emergency obstetrics and newborn care (BEMOC) and Comprehensive emergency obstetrics and newborn care (CEmOC) services, including postnatal care;
- High burden of non-communicable disease;
- High staff attrition rate;
- Inadequate access to safe drinking water; and
- Inadequate access to Basic and Comprehensive Emergency Obstetric and New born Care Services.

Health area

CSD has, in the health area, focused on a high impact areas and delivering rather than spreading its support to a multiple areas. Good efforts have been made to increase the knowledge, skills and capacity of the various actors operating within in the health structure i.e. nurses, assistants in Regional and Village Development Health Teams and Village Support groups as well as Multi-Disciplinary Facilitation Teams and volunteers including CBCs.

At end 2018, 48 Health Workers had been trained to manage complications of maternal, new-born, childhood illnesses; 50 Village Health Workers trained in order to decrease referrals to health facilities/clinics; and 120 professionals trained on Baby-friendly hospital Initiatives with NaNA.

Regarding service provision, the Integrated Management of Acute Malnutrition (IMAM) program is implemented jointly with WFP, NaNA and MoH (and training of staff). In the treatment of Severe and Acute Malnutrition, UNICEF is the sole agency, and in 2018, the total number of children admitted for rehabilitation are 3434, of which 84,3 per cent were cured. In 2017, total admitted was 5793 out of which 88,3 per cent was cured.

Good efforts are made to increase supply resources (medicines, equipment) to health clinics.

Protection from disease through immunization has resulted in high rates, namely 94 percent of DTP3 which was 4 per cent above the target. The process of cold chain capacity for vaccines has been improved, and now 81 per cent of the facilities improved cold chain capacity.

The Reproductive Maternal Neonatal Child and Adolescent Health (RMNCAH) system has been improved, with assessment of health clinics on maternal and new-born care. The *Nsaa Kenno* initiative was introduced in the new Country Program. It has helped to place focus on the Village Development Committee (VDC) as the centre at sub-national level. CSD has also helped implement an Integrated Community Case Management (ICCM) – in order to support community health workers to provide services.

Water, sanitation and hygiene area

CSD supports/works with the MoH and the Ministry of Fisheries and Water Resources (MoFWR). The functions of the new posts, C4D and CSD Officer that are "cutting across" CSD and PIC programs, have helped develop this component in the strive to have outputs on behavioural change, demand creation and utilisation of services. The intention is to enable the Country Office to better "promote behaviours" and attitudes among agents working for communities to improve health, education and child protection for children.

The status of ODF is nationally estimated at 99 per cent. *This is an achievement that from all stakeholders is attributed to UNICEF* - as it has been driving the concept of the CLTS participatory approach since 2009. CSD carried out monitoring of the Open Defecation Free (ODF) situation in 19 districts, in follow-up on 2016 activities.

WaSH activities have been allocated more funds in the new program. A post as WaSH Specialist has not been filled and has been vacant for more than one year. It was found that this will not be

filled any time soon for reasons that may be administrative in nature. Still, WaSH activities are ongoing and capable external assistance has been brought to the Country Office from Uganda.

Capacity building has been carried out on WaSH and advocacy on children´ rights have increased for health workers and community members. CSD has produced a Guideline for WaSH in Health Facilities (to be finalised) to be used in training. WaSH facilities i.e. VIP Latrines and quality water for hand washing with soap has been installed/provided in 51 schools (including some Madrasas). Some water structures have been rehabilitated villages and in the Kuntaur Health Centre. The CSD plans to renew the CTLS activities in a number of villages during the first half of 2019.

Emergency response

During the latter part of 2018 food security in the country was severe due to the fact the rains were delayed resulting in less crops and less food in communities. UNICEF-CSD contributed to an Emergency Response Plan and ensured that response plans in the relevant sectors were updated for *Health, Nutrition and WaSH.* The National Disaster Management Authority (NDMA) is the government authority in charge in times of emergency and The Gambia Red Cross is on standby, with a renewed commitment up to 2020. During the current program, the CSD Manager has assumed the role of Focal Point and Emergency Management Team (EMT) within the UN group (including WFP, FAO and WHO).

Recently, a study on the status of services that are rendered by hospitals and health centres in the country was conducted – with contributions from UNICEF-CSD. The study assessed the situation and the status of maternal, new-born, and child health *services*.[117] Table 3. shows, among other, the grave challenges/problems the country has to address, such as high maternal mortality rate; high deaths during the first month of life – especially in the first week; high prevalence of malnutrition; high fertility rate; and high rate of Mother to Child Transmission (MTCT) and HIV.

The results also suggested that the performances of health staff in the management of new-born and child care services generally were good – but that the staff emphasised the need for continuous training of skilled health personnel (competent health-care professionals) with competencies in intrapartum care, i.e. the time period spanning childbirth, from the onset of labour through delivery of the placenta.

The program worked at **policy level** (up-stream) in support of the national objectives. A Health Sector Bottleneck Analysis was carried out in 2014, coupled with an investment plan. The same year, a PMTCT (HIV) Bottleneck Analysis was undertaken and a Policy and Strategic Plan to reduce Malaria for the period 2014-2020. During the same period, the Integrated Management of Acute Malnutrition (IMAM) was undertaken, and preparations were made for the Nutrition Bottleneck Analysis, and a SMART Nutrition survey.

These are some other lessons from the previous CSD program mentioned in an internal CSD review document:

- Need for strengthening social mobilization around urban areas to increase uptake;
- The solarization of the cold room in Bansang has ensured reliable alternative source of energy;
- Strengthening advocacy was required for the purpose of having one national rural water and sanitation plan;
- UNICEF advocacy of the United Nations Country Team (UNCT) level triggered humanitarian response and created avenues for partnership. An umbrella PCA has been

[117] *Health Facility Assessment on Maternal and New-born Care, The Gambia*, UNICEF 2019 (draft - part of a wider study, incomplete as yet). The assessment collected data from sixteen (16) public health facilities. 5 hospitals, 6 Major Health Centres and 5 Minor Health Centres. Table 3. is compressed due to space consideration.

drafted for engagement of GRCS on emergency response and programmatic implementation;

- The joint collaboration with WFP had enabled the NDMA to take the lead for coordination of response;
- The district countdown to 2017 initiative was a “pushing factor for district authorities to move the ODF agenda”
- There is a need for exploring and engaging NGOs in implementation of activities i.e. Child Fund and GRCS.
- The tripartite platform is making good progress in delivering joint efforts in influencing policy and programmes at MoH . This could also be used to raise WASH in Health facility agenda.

ANNEX IV. EVALUATION QUESTIONS

Below is a list of evaluation questions. Efforts were made to avoid applied research questions - in search for descriptive answers - and focus on questions that relate to merit, worth and significance. They are sorted under each of the evaluation criteria, as the responses to these would help gauging to what extent outcomes were attained and outputs produced:

Relevance and strategic fit

1. To what extent is the current CSD program objectives and outcomes relevant to the i) Government's priorities and development agenda; and ii) the SDG targets and indicators?
2. To what extent is the CSD program complementing other UN organisations and development partners in supporting the Government in reaching most vulnerable in the health sector at national, district and community levels?
3. What perceptions do the key partners and stakeholders hold of the current CSD program relevance in comparison to the 2012-2016 (with the understanding that this is subject to the stakeholders´ institutional memory)?

Effectiveness

4. What is the significance of key changes made to the design/Theory of Change of the current CSD program (vis-à-vis the 2012-2016 program) in terms of reaching CSD outcomes for children – at national, district, and local community levels?
5. To what extent did the previous CSD program achieve its intended outcomes and objectives?
6. To what level does coherence and synergy exist between the CSD and PIC programmes (in design and implementation) - to help reach the objectives and outcomes?
7. To what extent has the current and previous CSD program engaged civil society organisations (CSOs) in the program and helped develop their capacity to advocate for children´s health?
8. To what extent did UNICEF-supported activities ensure that the most vulnerable children and women have access to basic health services to reduce child illnesses?
9. Which are the factors (internal and external to UNICEF) that contributed the most to achievement and performance of the previous and current CSD program?
10. Which are the factors (internal and external to UNICEF) that hindered the most the success of the CSD Programme?
11. To what extent have unexpected outcomes (positive and negative) occurred as a result of the CSD Program activities?
12. To what extent did strategic partners and partnerships contribute to the attainment of the CSD program results?

Efficiency

13. Could less/fewer resources have been used through alternative strategies with the same goals in mind - but with the same or higher level of achievements?
14. To what extent did the partnerships help keep down the costs of program delivery?
15. To what extent did the CSD program budget factor-in the cost of specific activities, outputs and outcomes to address the cross-cutting issues (mentioned below)?

Impact orientation

16. What impact has the previous CSD program had (2012-2016) in the three core areas of: Health/HIV, nutrition and WaSH and the current program (to date) - at national, district and community levels?

17. To what extent has the previous and current CSD program made a difference and positive impact on the reduction of childhood illnesses and child mortality?

Sustainability - and the likelihood of sustainability

18. To what extent has UNICEF-CSD achieved in contributing to sustainability and continuation to provide and improve WASH infrastructure and transferring knowledge and awareness regarding community-based interventions such as Community Led Total Sanitation (CTLS) and Communication for Development (C4D).
19. What mechanisms (if any) have been put in place for/by the Government to enable continuation of certain other key CSD activities supported through UNICEF during the previous program period (e.g. human resources, funding for supplies, drugs, vaccination campaigns)?
20. To what extent (if at all) have CSD program strategies and activities been replicated by the Government and other partners?

Lessons learned and potential good practices

21. To what extent has UNICEF documented lessons from the CSD program, i.e. from the previous programme 2012-2016, and/or the current programme?
22. To what extent have lessons been communicated and shared with the stakeholders?
23. To what extent has CSD and PIC learnt from earlier lessons regarding synergy between the two programs?
24. What should have been done differently (if any) and what should be avoided in the current or future phases of the CSD?
25. What good practices exists that can be replicated in other UNICEF CSD programs in other countries?

Equity concerns

Globally, UNICEF views equity as having many dimensions and many levels, including legislation, policy and within sectors (education, social policy, child protection, health). Equity is based on the principle of universality guaranteeing the fundamental rights of every child, regardless of gender, race, religious beliefs, income, physical attributes, geographical location or other status. These are questions to be posed regarding equity:

1. To what extent has UNICEF-CSD advocated for equity for children in relation to access to health care, HIV prevention and treatment, food and nutrition, water and sanitation and hygiene in schools at national policy level?
2. How has CSD addressed equity issues in the implementation of various community-based interventions, such as Community for Development (C4D), Community Total Led Sanitation (CTLS), VIP latrine construction, immunization and Training and capacity-development of the Partners ministries and Civil Society Organization staff?
3. How are undocumented/unregistered children born in the Gambia, as well as children on the move (coming from other countries) and their caretakers benefitting from CSD´s policy advocacy, and/or program interventions?
4. In which way has social protection measures supported by UNICEF (e.g. through BReST) benefitted mothers and children in income-poor households in the most disadvantaged regions?
5. How has CSD (current and previous program) addressed disabilities among children and mothers within the focus areas and attempted to increase the population´s understanding of their challenges in its core areas?

ANNEX V. DOCUMENTS CONSULTED

This list is not exhaustive as more documentation is likely to surface during the second field visit – it will be in draft evaluation report.

1. Revised Evaluation Policy of UNICEF (2018)
2. UNICEF-Adapted UNEG Evaluation Reports Standards, 2017
3. Integrating Human Rights and Gender Equality in Evaluation, UNEG, 2014
4. UNEG Ethical Guidelines for Evaluation, UNEG, March 2008
5. GEROS (Global Evaluation Reports Oversight System), UNEG
6. UNICEF-Adapted UNEG Evaluation Reports Standards
7. UNICEF-Adapted UNEG Quality Checklist for Evaluation Terms of Reference
8. Agenda for Sustainable Development, 2030
9. Government of the Gambia, National Development Plan (Draft), 2017 (including vision of the new Gambia)
10. The Gambia National Development Plan (NDP) 2018 - 2021 (and the Popular Version)
11. Health Management Information System Strategic Plan
12. The National Health Policy, 2012-2020
13. The National Monitoring and Evaluation Plan for the National Health Strategic Plan (NHSP), 2014-2020, April, 2015, The Gambia, Ministry of Health and Social Welfare
14. Health Sector Development Plan, The Gambia, 2014-2021
15. World Bank Country Profile – the Gambia
16. Toward a New Gambia: Linking Peace and Development, January 2018, International Peace Institute
17. Social Protection Policy 2015-2025, Ministry of Finance and Economic Affairs (2014) National Final draft, December 2014
18. World Bank, Macro Poverty Outlook for Sub-Saharan Africa: The Gambia, October 2017[118]
19. The Gambia National Gender Policy 2010- 2020
20. The Gambia after Elections: Implication for Governance and Security in West Africa," Friedrich Ebert Stiftung, 2017
21. Impact Evaluation Midline Survey Report, Maternal and Child Nutrition and Health Results Project, The Gambia, World Bank Group January 2018
22. National Reproductive Health Policy 2007 – 2014
23. Gambia Revised National Youth Policy 2016-2018
24. United Nations Development Assistance Framework, The Gambia (UNDAF 2012-2015) and the current UNDAF 2017-2021
25. Country Programme Document, The Islamic Republic of Gambia, UNICEF The Gambia 2017-2021, 15 July 2016 (includes Annex 1: Results and resources framework)
26. UNICEF Country Programme Action Plan 2012 – 2016
27. Programme strategy note for child survival and development, Programme of cooperation 2017-2021, UNICEF, The Gambia
28. In-depth Review of the Government of The Gambia and UNICEF Country Programme Action Plan 2012 – 2016.
29. Improving access and quality of Early Childhood Development programmes, experimental evidence from the Gambia, Policy research working paper 8737, World Bank Group February 2019
30. Multiple Indicator Cluster Survey 2018, Survey Findings Report, November, 2018
31. The Gambia Multiple Indicator Cluster Survey 2010, final report, June 2012, The Gambia Bureau of Statistics and UNICEF
32. United Nations Children's Fund
33. 2013 Gambia Demographic and Health Survey (GDHS)
34. UNICEF Country Office Annual Reports (COAR)

[118] http://pubdocs.worldbank.org/en/214601492188159621/mpo-gmb.pdf;

35. Country Office Annual Report 2016 – Narrative
36. Results Assessment Module-RAM 2015
37. UNICEF Work plans and. budgets and expenditure statements
38. Situation Analysis of Children and Women in The Gambia, UNICEF, Final version Submitted 9 December 2015
39. Situational Analysis of Children and Women in The Gambia, UNICEF 2010 (draft).
40. Business Operations Strategy document under the lead of UNICEF (aligned and supports the UNDAF for the period 2017-2021 and the implementation started from September 2017)
41. National Nutrition Survey, the Gambia using standardized monitoring and assessment survey methods of relief transition (SMART) methods'
42. Annual Report of the Resident/Humanitarian Coordinator on the use of CERF grants, 1 September 2014 – June 30, 2015
43. Donor progress and utilization reports (GAVI reports, and reports on Measles, Rubella vaccines, meningitis)
44. UNICEF Annual Report 2017 (overall for UNICEF)
45. 2018-2019 UNICEF The Gambia RWP Summary
46. How to design and manage Equity-focused evaluations, by Michael Bamberger and Marco Segone, UNICEF
47. Global Evaluation Reports Oversight System (GEROS) January 2013, UNICEF
48. UNICEF-Adapted UNEG Evaluation Reports Standards, July 2010
49. UNICEF Evaluation Report Standards, Evaluation Office, UNICEF NYHQ, September 2004
50. UNEG Code of Conduct for Evaluation in the UN System, UNEG, March 2008
51. United Nations Evaluation Group, Ethical Guidelines for Evaluation, Draft April 5, 2007
52. The DAC Guidelines Strategies for Sustainable Development: Guidance for Development Co-operation
53. Log-frame for the Country Programme 2017-2021, Child Survival and Development
54. UNICEF CPD and strategic plan 2014-2017
55. 2012 Mid-year review of Rolling Work Plan 2012-2013 (Child Survival and Development Programme), a PPT
56. 2013 END-Year Review of 2012-2013 Rolling Work Plan (Child Survival and Development), a PPT
57. End-Year Review of 2018-2019 Rolling Work Plan (CSD section), 2017
58. UNICEF field trip reports, The GAMBIA (various)
59. Children's Act of 2005
60. National HIV and AIDS Policy
61. Health Policy
62. National Nutrition Policy (2010-2020)
63. National Gender Policy 2010-2020
64. Education Policy 2004 – 2015
65. 2014 Child Protection Policy
66. National Social Protection Policy 2015-2025 (NSSP) (Gambia's first)
67. 2001 Expanded Programme on Immunisation (EPI) Policy
68. Water and Sanitation Policy
69. Revised National Youth Policy 2016-2018
70. The Gambia Micro-nutrient study 2018. Final Report 25 March 2019, National Nutrition Agency (NaNA)-Gambia, UNICEF, Gambia Bureau of Statistics (GBOS), GroundWork. Gambia National Micronutrient Survey 2018. Banjul, Gambia; 2019.
71. Key "Bottleneck analysis": On PMTCT (Prevention of mother-to-child transmission), water and sanitation, and nutrition).
72. Article "EU remains key supporter in addressing nutrition insecurity in Gambia -EU Ambassador" in the Point, 14 May 2018

73. The Gambia: Functional Review of Social Protection Coordination Mechanism (Secretariat), Final Report, Andrew Wyatt, Marian Guest, Joanna Woodroffe-King, Alexandra Doyle, June 2018
74. Health Facility Assessment on Maternal and New born Care, The Gambia, part of the (Draft) Health sector performance assessment report
75. mHealth New Horizons, Volume 3, WHO
76. Leading the Realization of Human Rights to Health and through health
77. Report of the High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents, WHO
78. Trends in Maternal Mortality: 1990 to 2015, Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

ANNEX VI. PERSONS MET

The following are among the persons that have participated in FGDs, in-depth interviews, meetings and consultations to date.[119]

Name	Designation	Organisation	Participated in Focused Discussion	Participated in in-depth Interview
Sandra Lattouf	Representative	UNICEF		x
Shahid Mahbub Awan	Dy Representative (also CSD Manager)	UNICEF		x
Baba Muatafa Marong	PM&E Specialist	UNICEF		x
Mariama Janneh	Health Specialist, Ag. CSD Manager	UNICEF		x
Esther	UN Volunteer, WASH	UNICEF		x
Yankuba Sawo	Nutrition Specialist	UNICEF		x
Aminatta Sarr	Nutrition Officer	UNICEF		x
Mariama Janneh	Health Specialist	UNICEF		x
Ebba Secka	Programme Officer, C4D and WaSH	UNICEF		x
Tina Ceesay Bojang	Programme Finance and Financing	UNICEF		x
Maxime Germain	PIC Manager	UNICEF		x
Momat Jallow	C4D (Cross-cutting)	UNICEF		x
Buya Jallow	Immunization Manager	UNICEF		x
Zahra Bedi	Operations Manager	UNICEF		x
Yolande Ramos	Sr. Human Resources Specialist	UNICEF		x
Andrea Broggi	Independent consultant (judiciary/juvenile justice) for UNICEF)			x
Kawsu K. Bojang	Coordinator, Integrated Management of Neonatal and Childhood Illness (IMNCI)	MoH		x
Mbenky F Saidy	Coordinator, Prevention of mother-to-child transmission, PMTCT	MoH		x
Momodou L. Darboe	Deputy Program Manager, Reproductive and Maternal Child Health Services, RMNCAH	MoH	x	
Abdou K. Jallow	Programme Officer, Reproductive and Maternal Child Health Services (RMNCAH)	MoH	x	
Ibrahim Jaiteh	Program Officer, Reproductive and Maternal Child Health Services RMNCAH	MoH	x	
Balkisy Garber	Program Officer, Reproductive and Maternal	MoH	x	

[119]Confidentiality was a concern in the community FGDs and the participants (including volunteers) were treated anonymously therefore their names are not provided here. A few names of staff members in Kaif Health Centre, LRR, were also not recorded.

Name	Designation	Organisation	Participated in Focused Discussion	Participated in in-depth Interview
	Child Health Services RMNCAH			
Robert Sambou	Ag. Program Manager, School Health and Nutrition Unit, Directorate of Health Promotion and Education (DHPE)	MoH	x	
Yahya Kandeh	Program Officer, School Health and Nutrition Unit, Directorate of Health Promotion and Education (DHPE)	MoH	x	
Mariama Dampha	Program Officer, School Health and Nutrition Unit, Directorate of Health Promotion and Education (DHPE)	MoH	x	
Fatou A. Darboe	Program Officer, School Health and Nutrition unit, Directorate of Health Promotion and Education (DHPE), Health Communication Unit,	MoH	x	
Rohey Njie	Sr. Program Officer, School Health and Nutrition unit (DHPE), Health Communication Unit,	MoH	x	
Mass Joof	Program Officer, School Health and Nutrition unit (DHPE), Health Communication Unit	MoH	x	
Lamin FM Barrow	Sr. Program Officer, School Health and Nutrition Unit (DHPE), Communication Unit	MoH	x	
Dawda Sowe	Program Manager, Ministry of Health, Expanded Programme for Immunization (EPI)	MoH	x	
Lamin Ceesay	Sr. Logistician, EPI	MoH	x	
Sidat Fofana	Dy Program Manager, EPI	MoH	x	
Bolong Jobarteh	Director, Public and Environmental Health	MoH		x
Lamin Fadera	Program Manager, WASH, Public and Environmental Health	MoH		x
Dembo Fatty	Program Manager, Public and Environmental Health	MoH	x	
Fatou Samateh	Pharmacist	MoH	x	
Fatou Njie	Pharmacist, Directorate of Pharmaceutical Services	MoH	x	
Ally Kilino,	Technical Adviser (Consultant) to the DoPS	MoH	x	

Name	Designation	Organisation	Participated in Focused Discussion	Participated in in-depth Interview
Omar Mbakeh	Principal Health Planner, DPI, Directorate of Planning	MoH		x
Dr. Musa M. M. Sowe	Head of HMIS, Directorate of Planning	MoH		x
Musa M. Loum	Program Manager, Primary Health Care (PHC)	MoH	x	
Adam Homma	Program Officer, Primary Health Care (PHC)	MoH	x	
Balla Kandeh	Program Manager, National Malaria Control Programme	MoH	x	
Mr. Lamin Saidyleigh	Program manager, Dept of Water Resources, Banjul, CRR	Ministry of Water Resources and Fisheries		x
Jammeh Sillah	Nurse, Kaif health Centre		x	
Name was not recorded	Kaif Health Centre, Regional Directorate, MoH, LRR	MoH	x	
Name was not recorded	Kaif Health Centre, Regional Directorate, MoH, LRR	MoH	x	
Names was not recorded	Kaif Health Centre, Regional Directorate, MoH, LRR	MoH	x	
Community members *(taking part in the FGD in the Health Centre)*	Kaif Health Centre, Regional Directorate, MoH, LRR	MoH	x	
Village Head (*Alkalo*)	Kaif Health Centre		x	
Name were not recorded	Headmaster, Madrassa, Bansang, CRR		x	
Name was not recorded	School Teacher, Bansang, CRR		x	
Name was not recorded	School Teacher, Bansang, CRR		x	
Community members and school volunteers (*Names was not recorded)*	Bansang, CRR		x	
Ms. Majula Kuyateh	Regional Health Team Member, RHT, Regional Directorate,Basse, URR	MoH	x	
Mr. Ebejma	Principal Nurse and Administrator, RHT, Regional Directorate, Basse, URR	MoH	x	
Mr. Seck	NFO, Basse, URR	MoH	x	
Mr. Modu KO Njie	PPITO, RHT, Basse, URR	MoH	x	
Mr. Kelefa Kandeh	Regional Health Officer, RHT, Basse, URR	MoH	x	
Mr. Lamin Kebbeh	Manager	CREN, Basse		x
Mr. Samba Jawara	Community Health Worker, Sara Pirasu Village, Basse, URR		x	

Name	Designation	Organisation	Participated in Focused Discussion	Participated in in-depth Interview
Mr. Mamudou H. M. Jobarteh	Community Health Nurse, Sara Pirasu Village, Basse, URR		x	
Name was not recorded	Community Birth Companion (CBC), Sara Pirasu Village, Basse, URR		x	
Name was not recorded	(Temporary) Village Head, Kindibaru Village, Basse, URR		x	
Community members *(five women, names not recorded)*	Kindibaru Village, Basse, URR		x	
Ms. Kodou Ndure	Community Health Nurse (extension worker, MDTF)	MoH,	x	
Mr. Lamin Jaffa	Livestock Assistant (extension worker, MDTF)	Ministry of Agriculture	x	
Mr. Samba Camara	Livestock Assistant (extension worker, MDTF)	Ministry of Agriculture	x	
Mr. Abdou S. Gassama	Deputy Principal, Lower Basic School, RHT, Firdawsy, CRR	MoH		x
Mr. Abdoulie Jarju	Principal Nursing Officer, RHT, Farafenni, NBE	MoH	x	
Mr. Ebrima F. Colley	Regional Health Promotion and Education Officer RHT, Farafenni, NBE	MoH	x	
Mr. Baba Njie	Project Management Officer, RHT	MoH	x	
Mr. Baba Jatta	Nutritional Field Officer, RHT	MoH	x	
Mr. Saikou Dibba	Financial Management Assistant, RHT,	MoH	x	
Mr. Bakary	Program Manager	NaNA	x	
Mr. Moussa	Sr. Program Officer	NaNA	x	
Mr. Alieu	Principal Program Officer (Focal Point for UNICEF)	UNFPA		x
Mr. Alien Jammeh	Program Analyst Reproductive Health Commodity Security (RHCS)	UNFPA		x
Ms. Wanja Kaira	Representative/Country Director	WFP		x
Ms. Tamsin Ab. Cham	Program Policy Officer, School Feeding Tamsir.cham@wfp.org	WFP		x
Dr. Sadaf Sardar	Nutrition Specialist Sadaf.sardar@wfp.org	WFP		x
Mr. Bakery Tijan Jargo	Programme Officer (Family & Reproductive Health, EPI, Nutrition)	WHO		
Mr. Solange Heise	Nutrition Officer	Food and Agriculture		x

Name	Designation	Organisation	Participated in Focused Discussion	Participated in in-depth Interview
		Organisation (FAO)		
Ms. Sirra Horeja Ndow	Country Director	UNAIDS		x

ANNEX VII. VALIDATION MEETING 16 MAY 2019: AGENDA AND PARTICIPANTS

The Agenda for the meeting:

1. **Background**

- What guides UNICEF in The Gambia?
- Two programs components: Child Survival and Development (CSD) and Protection and Inclusion of Children
- What should CSD contribute to (outcomes)?
- What strategies are applied?
- What is the logic behind how change will happen?
- Evaluation purpose, objectives and scope

2. **Preliminary findings**

- Relevance of the CSD program
- Key problems
- Recent figures on health; stunting, wasting (nutrition-specific), WaSH
- Policy development and strategic plans (previous and current program periods)
- Capacity development, technical assistance for better service delivery
- Issues high on CSD´s agenda for the coming two years
- Nexts steps of the evaluation process

3. **Question and Answer Session**

Participants

No.	Name	Designation	Organisation
1	Karamba Keita	Deputy Permanent Secretary-Technical (PS)	Ministry of Health (MOH)
2	Alieu Kujabi	Principal Programme Officer-NaNA	National Nutrition Agency (NaNA)
3	Alhajie Kolley	PASRH	UNFPA
4	Mbinki F Sanneh	PMTCT Coordinator	MNCAH Project, MOH
5	Chaba Saidykhan	Programme Manager,	Department fo Water Resources
6	Yankuba Sawo	Nutrition Specialist,	UNICEF
7	Sanjally Trawally	Assistant Director, Health Promotion and Education	Ministry of Health
8	Buba Darboe	Programme Manager	HCU- Ministry of Health

No.	Name	Designation	Organisation
9	Fatou A Darboe	Programme Officer	Nutrition Unit, Ministry of Health
10	Mariama Janneh	Health Specialist	UNICEF
12	Yai Fatou Gaye	Construction Engineer	UNICEF
13	Buya Jallow	Immunization Officer	UNICEF
14	Dr. Shahid Aswan	Deputy Representative a.i	UNICEF
15	Aminatta Sarr	Nutrition Officer	UNICEF
1	Ebrima Bah	PHC Unit	MoH
17	Dr. Sadaf Sardar	Nutrition Consultant,	WFP
18	Margie Rehm	Deputy Country Director,	WFP
19	Sirra Ndow	Country Director	UNAIDS
20	Bolong S Jobarteh	Director, Public Health,	MoH
21	Andrea Broggi	Consultant	UNICEF
22	Nuha Jatta	Education Specialist	UNICEF
23	Ebba Secka	CSD Officer	UNICEF
24	Gloria Momoh	Partnership Manager	UNICEF
25	Lotta Nycander	Consultant	UNICEF
26	Momodou Ceesay	Health Economist	WHO
27	Michael Jammeh	Programme Officer-IMNCE	MoH

No.	Name	Designation	Organisation
28	Sobinge Heise	Programme Coordinator/Nutrition Officer	FAO
29	Ebrima S Jabbie .	Health Officer	GRCS
30	Kausu Sillah	Programme Officer, NYC	NYC
31	Muhammed s Jaiteh	Permanent Secretary 1	MoH
32	Omar Jallwo	SPO	UNICEF
33	Lala Laiteh	Deputy Permanent Secretary	MOH

ANNEX VIII. KEY UNICEF-CSD CONTRIBUTIONS AT POLICY LEVEL 2012-to date

Policy level activities 2012-2016		Policy level activities 2017-2021	
Health	Health Sector Bottleneck Analysis in 2014, and an Investment plan	**Health**	Reproductive, Maternal, Neonatal, Child and Adolescent Health (RCMNCAH) Policy (2017-2026); and Health policy (2017-2026)
	Prevention of Mother to Child Transmission (HIV) Bottleneck Analysis		Strategic Plan for the Reproductive Maternal New born Child and Adolescent Health (2017-2022)
	A Policy and Strategic Plan to reduce Malaria 2014-2020		Roadmap for Revitalizing and Scaling-up of Primary Health Care.
Nutrition	Integrated Management of Acute Malnutrition (IMAM)	**Nutrition**	Nutrition Bottleneck Analysis in 2017
	Preparations for the Nutrition Bottleneck Analysis, and a SMART Nutrition survey.		National Nutrition Policy and the new Nutrition strategy
WaSH	A Sanitation Bottleneck Analysis in 2014	**WaSH**	Wash Bottleneck Analysis in 2017
	Ministers´ commitment to eliminate OD by 2015, which was perceived as a milestone,		WASH Action Plan and 2017 Annual Work Plans for the WASH sector
	National Sanitation Policy (to be effective in 2017) adopted by the Cabinet in February 2016		National Open Defecation Free (ODF) Action Plan, 2017
Cutting across	MICS survey (2018, unpublished) and the Nutrition Micronutrient survey (2018) – supported by UNICEF		

ANNEX IX. SURVEY QUESTIONNAIRE FOR UNICEF STAFF MEMBERS

CONFIDENTIAL

1. Technical support

In your position and work for CSD program, UNICEF, how do you rate the overall technical or moral support received from your immediate supervisor in order to perform you work?

Excellent	Good	Satisfactory	Not satisfactory

Please explain if not satisfactory:

……..

2. Admin/finance support

In your work for CSD program, UNICEF, how do you rate the overall admin/finance support received from within the CO?

Excellent	Good	Satisfactory	Not satisfactory

Please explain if not satisfactory:

……..

3. CSD program´s achievement

a) Could you mention three key achievements of CSD that are you most satisfied with?

……

b) Which factors contributed to these achievements?

……

c) Could you mention three non-satisfactory program components/activities?

……

d) Which were the contributing factors that these components have not been satisfactory (or not yielded good results)

……

4. CSD and PIC working in unison

To what extent have the two program components (CSD and PIC) worked in unison (here I mean: having joint work sessions, field visits, assessments, common understanding about CSD outcomes and priorities, approaches, methodologies and/or "working culture")

Fully in unison	Partially in unison only	Not at all in unison

Please explain

……..

5. Obstacles and/or challenges?

a) Have you faced any particular obstacles/challenges in performing your job in the project? If, yes, please describe:

……..

b) To what extent were you able to overcome the obstacles/challenges to date?

Fully	Partially	Not at all

c) Please explain

…….

6. What could be done differently?

What could the program do differently to reach the CSD outputs and outcomes?
This could include the program design, implementation, monitoring system, cooperation with program participants (stakeholders), capacity development or services - or any work related aspect of CSD that you wish to highlight.

……

7. Finally, how do you rate the CSD overall achievement to date?

Excellent	Good	Satisfactory	Not satisfactory

Thank you very much – I very much appreciate your cooperation.

Lotta Nycander

Independent consultant

The Gambia, 17 May 2019

ANNEX X. SURVEY QUESTIONNAIRE FOR STAKEHOLDERS

CSD-UNICEF EVALUATON March – May 2019

Brief Questionnaire

Stakeholders of UNICEF´s Child Survival and Development Program

The current UNICEF Country Programme (2017 – 2021) includes two components: The Child Survival and Development (SDC) component and the Protection and Inclusion of Children (PIC) component. The CSD is aiming at attaining outcomes in health, nutrition and water, sanitation and hygiene (WASH).

In the process of gathering information for this evaluation, I would greatly appreciate if you could kindly participate in responding to a few questions. Your responses will help UNICEF and other development partners improve the program in the coming months.
Your response will be kept strictly confidential - so feel free not to put your name on the Questionnaire and also know that you are free not to participate.

Question 1: To what extent has the partnership with UNICEF´s CSD program contributed to the attainment of your organization's Child Survival and Development goals:

a) During the last 3-4 years; and b) Before 2016 (if applicable)?

Time periods	Very much	Quite a lot	Not so much	Not at all
2016-to date				
Before 2016				

Please explain:……
……..

Question 2: In which one of the following areas has your organization benefited (if in any way) from the partnership with UNICEF?

Areas of cooperation	Any benefit? YES/NO	Please provide more details *(For instance: learning; exposure to new work area; expanded network; more effective work done; better monitoring; or other)*
Discussion partner on UNDAF		
Working group		
Participation in training or workshops		
Participation in visits		
Support provided to our program participants ("target group", "beneficiaries")		
Other area		

Question 3: If there is any aspect of your partnership with UNICEF that has *not* worked as well as you would have expected – how could it/they be improved?

Please explain:

……
……

Question 4: How could partnership with UNICEF – CSD program be improved in the future to bring more value to the work of:

a) Your organization (as a whole, e.g. systems, strategies, resources)?

……

b) Staff members of your organization (capacity development, learning, taking part in various UNICEF related activities)

……

c) Children and women in accessing better quality health care, improved nutrition and water and sanitation and hygiene, WaSH?

……

Questions 5: What should be done to ensure that efforts and/or benefits in the area of health, nutrition and water, sanitation and hygiene (WASH) will continue (be sustained)?

Please explain:……
……

Question 6: Do you have any additional comments or suggestions?

……

ANNEX XI. DETAILED INFORMATION ABOUT CSD ACHIEVEMENTS 2012-2016 and 2017-2021

A number of **capacity development and awareness/sensitization activities were taking place in the *previous CSD program 2012-2016***: 55 village health workers in URR and NBR; capacities of 60 community health workers were built on the in CRR, URR and NBR; 25 central and regional staff were trained on cold chain inventory to institutionalize the system at central and regional levels; 70 religious leaders from all the 7 health regions were sensitized on the uptake of immunization services; 290 health workers were trained in the IMAM approach and as a result, 4390 out of 6251 children targeted were reached. 72 health workers trained from URR, CRR and NBRE to be able to effectively management of maternal and new born complications; 25 midwives were trained on the use of the partograph to monitor progress of labour; 20 health workers from all 7 regions were trained on IMNCI. The training strengthened the capacity of health workers on IMNCI case management and reinforce skills acquired.[120] As part of nutrition surveillance activities, a total of 882 community volunteers were trained in community mobilization and screening for acute malnutrition. These volunteers then screened a total of 11, 806 children under five for acute malnutrition. The biannual nutrition surveillance activity to screen for malnutrition was also supported.

A total of 85 Village Support Group members and other influential leaders **were made aware** of IYCF, WaSH, and Nutrition in Lower River Region as part of the efforts to prevent malnutrition. The program also carried out community level (down-stream activities), including **providing drugs and other supplies** to 228 PHC villages, benefitting 4,762 children particularly in URR and CRR – which were the areas that UNICEF supported during this period. **Construction and rehabilitation of toilets** with hand washing facility including girls´ hygiene unit was done for 15 PIQSS schools, benefiting 3,700 pupils. **CSD constructed new water system** in 2 schools and rehabilitated water points in 10 schools reaching 8,000 children. Assessment of OD status in regions were completed and 298 OD communities were identified and persuaded ("triggered") and 121 were declared ODF and verified – which was a major milestone in the count-down to 2017 ODF districts.[121]

In the ***current CSD progam 2017-2021***, in 2018, UNICEF carried out a campaign to renew action to improve on WaSH and mobilise communities. **VIP latrines/pit latrines were constructed in 1700 households** n rural communities, out of which **300 were women-headed households**. The campaign involved the National Youth Council, who proved to be strong agents for change. It is clear, after visiting some communities in the NBE that even areas that have earlier been declared ODF, have to be encouraged to continue to construct latrines and spread knowledge about the dangers of OD, in particular for children under 5. A **number of significant achievements at policy leve**l was also made, related to the health sector was made such contributions to the Reproductive Maternal New-born Child and Adolescent Health policy (2017-2026) and Strategic Plan (2017-2022); and the Roadmap for Revitalizing and Scaling-up of Primary Health Care.

[120] Source: 2016 End-Year Review of 2015-2016 Rolling Work Plan, Child Survival and Development, UNICEF, The Gambia.
[121] Source: Ibid.

CSD´s support to offering services, improving quality of services and the health information system

Regarding the offering of services in the sector, the CSD has worked to support the Government and contribute to the strengthening the health systems in terms of increasing access to quality health care services in the targeted areas - and increase the capacity of the government staff and volunteers at village level to enable them to perform services in rural communities. Information and data about demand and use of health care services for children and mothers/caregivers who are the most vulnerable, and who are from poorest households in the NoN-PHC villages has not been found in the documentation available (COARS, RAM reports, internal PPT reviews).

Many actors in the sector have participated and benefitted from attending **CSD-supported capacity development activities** including VSG members, VHW and volunteers including CBCs, community influential local leaders including village leaders, faith-based leaders as well as regional and central ministry of health staff. To ensure that the relevant and diverse staff categories and volunteers in the sector are sufficiently equipped with knowledge and skills, various topics and themes have been on the agenda including cold chain inventory, the issue of uptake of immunization services, and the IMAM approach in which CSD has supported training of nurses and doctors on the national IMAM protocol for the treatment of acute malnutrition among children. Other areas of capacity development include the use of the partograph to monitor progress of labour and MNCI case management.

In the previous program, CSD provided medicines and drugs to 228 PHC villages in URR and CRR (2014 figure). CSD has supported the relatively high immunization coverage through its handling of the GAVI grant which has allowed for routine campaigns and services are reportedly the highest among the countries in the region – aiming at reaching each and every child in the country. The annual report for 2018 reported that in October 2018, 52,978 children have received DTP-containing vaccine, representing 65 per cent of the target population. The EPI unit, MoH at central level informed that access to immunization has increased with outreach to new sites reach within a 5 km areas. The cold chain equipment has also been expanded (EPI also supplies vaccines for immunization for free to private service providers). In order to further increase the demand and utilization of these services in urban areas to prevent children from acquiring preventable diseases there are still issues to be solved (related to a favourable physical environment).

CSD has been engaged in **constructing and rehabilitating toilets (latrines)** with hand washing facility and girls´ hygiene units and some new water systems in schools and health clinics. UNICEF-CSD has also strongly advocated for the Government to recognize the importance of having OD villages and WaSH in communities, villages and health clinics. In a campaign in 2018 VIP latrines/pit latrines were constructed in 1700 households out of which 300 were headed by women. The campaign involved the National Youth Council, who proved to be strong agents for change. It is clear, after visiting some communities in the NBE that even areas that have earlier been declared ODF would need to be encouraged to continue to construct latrines and spread knowledge about the dangers of OD, in particular for children under 5.

Some aspects of the program have focused specifically on improving the **quality of services**, such as in the area of nutrition, for which the IMAM protocol was reviewed, updated and endorsed by MoH to standardize and improve the quality of management of

acute malnutrition. The current program has improved efforts in planning and undertaking joint assessments through monitoring in the field (MoH, NaNA and UN agencies), partly to enable increased quality of the services. CSD staff recently participated with the MoH and key stakeholders in a joint health facility assessment in which the standard of selected hospitals and health clinics/facilities were surveyed. It was concluded that Maternal, Newborn and Child Health (MNCH) care was available in all minor health facilities that the team visited – however regarding emergency care none had the necessary skills or equipment and the capability to carry out lifesaving services (BEmONC) were not adequate.

Staff members have pointed out that the Annual Management Priorities for 2019 are a good example to be continued – in particular the cross-sectoral priority that will guide UNICEF and its programs in their daily work. Issues of quality are also seen in the handling of vaccines for the immunization campaigns, ensuring the safety and quality of the vaccines particularly through strengthening the cold chain system in three regional hubs, providing more storage capacity.

Regarding the issues of **increasing service demand** by the participating (targeted) population, the development of a C4D function is intended to generate not only a larger demand for but also a better utilization of services through downstream activities. This is thus an important part of the current program which entails promoting "critical and feasible behaviours" in the areas of health including HIV, WaSH and nutrition (as well as education and child protection which are areas PIC focuses on).

Regarding the health information system in the country, the IDR 2014 of the previous programme noted the fact that **Health Management Information System (HMIS)** was not capturing programme indicators in WaSH, nutrition, diarrhoea and pneumonia – and recommended that it should in the new (current) CSD program. CSD is contributing to HMIS through its joint field assessments and its support to MICS among other surveys. However, more data is required regarding the situation of children who are differently abled.

ANNEX XII. SUMMARY OF FINDINGS FROM SURVEYS

The following findings are from MICS 6, 2018, and the Micro-Nutrient Survey 2018, and was included in the Inception Report.

Health from MICS

- Under-5 mortality rate is at 57 and it declined from 61/1000 live births; under 5 mortality rural areas showing 64 and urban 53/1000 live births, - Kantuar LGA has the highest mortality at 77/1000 live births;
- Neonatal mortality rates have been on an increase from the last 5 years from 28 to 31/1000 live births. Within the LGAs, Kuntaur has the highest **neonatal mortality** rate of 38/1000 live births followed by Brikama (urban) LGA standing at 35/1000 live births; and
- One interesting finding relates to higher under 5 mortality rates for male child (64/100 live birth) as compared to 50/1000 live births for female children. The requires further in-depth analysis of causality.

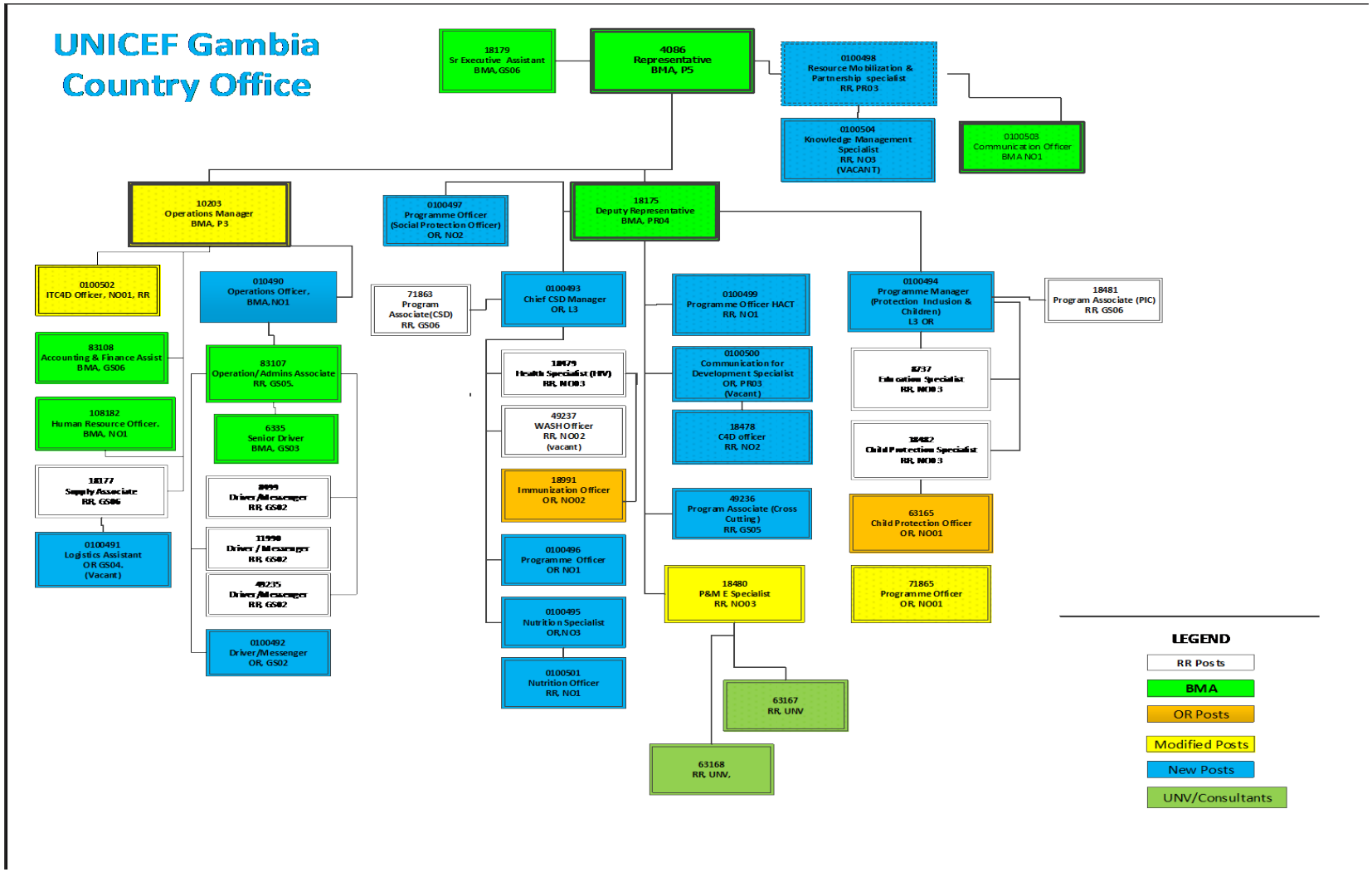
Nutrition from GMNS (Gambia Micronutrient Survey- 2018)

- Stunting: prevalence of stunting in children 0-59 months reduced from 23% (2015 SMART Survey) to 15.7%. stunting is higher in rural areas (15.9%) than among urban children at 7.8%. Kuntaur having highest 21.3% levels of stunting as compared to 6.9% in Banjul;
- Wasting: prevalence of wasting in 0-59 months old children also reduced from 10% (2015 SMART survey) to 6%. Rural children are more wasted 6.2% than urban 3.6%;
- More than 50% of Gambian children are anemic (hemoglobin <110 g/L). Prevalence is higher for rural children (57%) and boys (54%) as compared to urban (46%) and girls (45%); and
- Nationally, 18.2% of children have Vitamin A deficiency.

WASH from MICS

- 85% of the households have access to basic drinking water services, however only 34% (one third) of households are using safely managed drinking water services;
- Despite improved access to basic drinking water services, disparities still exist between urban 90% and rural 73% while Kuntaur has 66% of its population accessing basic drinking water services, the lowest compared to Banjul which is at 100%;
- 99% of the households are Open Defecation Free, with 62% having access to improved Sanitation;
- 31% of the household population were found with a hand washing facility with water and soap which is still very low; and
- 73% of households in The Gambia are at risk of faecal contamination of drinking water based on number of E. coli detected. The situation is worse for rural areas (92%)

ANNEX XIII. UNICEF COUNTRY OFFICE ORGANOGRAM



ANNEX XIV. EVALUATION MATRIX

The below evaluation matrix is an essential tool for *planning and organizing an evaluation*.

Evaluation criteria	Question	Data sources	Data collection methods
Relevance and strategic fit	1. To what extent are the current CSD program (2017-2021) objectives and outcomes relevant to the i) Government's priorities and development agenda; and ii) the SDG targets and indicators? 2. To what extent is the current CSD program (2017-2021) complementing other UN organisations and development partners in supporting the Government in reaching most vulnerable in the health sector at national, district and community levels? 3. What perceptions do the key partners and stakeholders hold of the current CSD program relevance in comparison to the 2012-2016 (with the understanding that this is subject to the stakeholders´ institutional memory)?	-National Development Plan (NDP) 2018 – 2021 - SDG Agenda - UNDAF 2007-2021 - Health Management Information System Strategic Plan -Health Sector Development Plan 2014-2021 -UN Websites - National policy documents	-Documentation review -In-depth interviews
Effectiveness	1. What key changes are made to the design/Theory of Change of the current CSD program, compared with the former 2012-2016 CSD program and, if so, is the shift likely to be more effective in terms of reaching core outcomes? 2. To what extent did the previous CSD program (2012-2016) achieve its intended outcomes and objectives? 3. To what level does coherence and synergy exist between the current CSD and PIC Programs (in design and implementation) - to help reach the objectives and outcomes (including on the subjects of gender, equity and human rights)? 4. To what extent have the current and previous CSD program engaged CSOs in the program and helped develop their capacity to advocate for children´s health?	- UNICEF CPD strategic plan 2014-2017 -Rolling Work Plans -2012 Mid-year review of UNICEF Program Document (PPT) - Log-frame for the UNICEF Country Programmes 2012-2016 & 2017-2021 -Results & Resources Frameworks, (ToC & LFA matrices), -Internal review documents	-Documentation review -In-depth interviews (national and sub-national level) -FGDs - Briefing sessions CO mgt & staff

	5. To what extent did UNICEF-supported activities during the earlier and current phase of the Program ensure that the most vulnerable children and women have access to basic health services to reduce child illnesses? 6. Which are the factors (internal and external to UNICEF) that contributed the most to achievement and performance of the previous and current CSD program? 7. Which are the factors (internal and external to UNICEF) that hindered the most the success of the previous and current CSD program? 8. To what extent have unexpected outcomes (positive and negative) occurred as a result of the CSD Program activities during the previous and current phase? 9. To what extent did strategic partners and partnerships contribute to the attainment of the CSD program results during the previous and current CSD program?	-UNICEF Annual Reports -Mid Term Review -Technical reports -MICS data -Reports from donor agencies -Sitan -Annual Reports (other UN partners) - Policy documents -- Results Assessment Module (RAM) reports	
Efficiency	*(In reference to the current CSD program)* 10. To what extent were financial resources, human resources and supplies: - Sufficient in quality and quantity? - Deployed in a timely manner? 11. Could less/fewer resources have been used through alternative strategies with the same goals in mind - but with the same or higher level of achievements? 12. To what extent did the partnerships help keep down the costs of program delivery? 13. To what extent did the CSD program budget factor-in the cost of specific activities, outputs and outcomes to address the cross-cutting issues (mentioned below)?	-Mid Term Review 2014 -Internal review reports -Data from ministries -Correspondence with donor agencies - Program Budgets -Expenditure documentation, -Audit reports -Donor progress and utilization reports - Results Assessment Module-RAM reports	-Documentation review - In-depth interviews - FGDs - Briefing sessions with CO mgt & staff

Impact	14. What impact has the previous CSD program had (2012-2016) had in the three core areas of: Health/HIV, nutrition and WaSH and the current program (to date) - at national, district and community levels? 15. To what extent has the previous and current CSD program made a difference and positive impact on the reduction of childhood illnesses and child mortality?	- MICS, DHS, Health Management data -Impact Evaluation Midline Survey Report -Mid Term Review 2014 -SiTAN, - National and sub-national policy documents - Data from RHCs and Rehabilitation centres - Annual reports and Results Assessment Module-RAM 2015 - Newspaper articles -reports from other UN agencies - UNICEF field trip reports and joint assessment reports (Gov/UN)	-Document review -In-depth interviews -FGDs -Briefing sessions with CO mgt & staff -Field observations
Sustainability	16. What mechanisms (if any) were put in place for/by the Government to enable continuation of certain key CSD approaches during the previous program period (e.g. benefits, systems, knowledge, human resources, funding for supplies, drugs, vaccination campaigns)? 17. To what extent (if at all) have CSD program strategies and activities been replicated by the Government and other partners?	-UNICEF annual reports and RAMs - Situation Analysis of Children and Women in The Gambia (SiTAN) & other technical reports - Reports to donors - Newspaper articles - Reports from international study tours and conferences - National and sub-national policy documents	-Document review -In-depth interviews -FGDs -Briefing sessions with CO mgt & staff

		- World Bank Policy research working papers -End-Year Review of 2018-2019 Rolling Work Plan (CSD section), 2017	

ANNEX XV. A CONSTRUCTED LFA MATRIX FOR CSD PROGRAM 2017-2021

The consultant constructed a LFA Matrix (as part of the Theory of Change referred to in the ToR) based on the structure (outcome, outputs) used in the current rolling work plan (RWP) (the details on activities inputs are found in the RWP).

Long-term goal	Children will benefit from immunization and other preventive services, childhood diseases will be recognized and treated appropriately and maternal, neonatal and child mortality will be reduced							
Outcomes	1.Gambian children and women have access to and utilize improved and equitable quality maternal and child health services, learn and practice healthy behaviours				2.Children, adolescent girls and women, especially the most vulnerable, realize their rights and utilize equitable and quality nutritional services and nutrition and care practices		3.Children and their families have improved and equitable access to and utilize safe drinking water and sanitation services and adopt improved hygiene practices and behaviours.	
Outputs	1.Strengthened PHC system provides equitable and quality maternal and child health services specifically for under 5s, pregnant and lactating women. *Including* institutional capacities built to provide equitable and quality RMNCAH services	2.A comprehensive RMNCAH communication plan is developed *(incorporating malaria, pneumonia and diarrhoea, PMTCT, immunisation, polio and child development)* budgeted and implemented	3.Village Health Workers trained to implement integrated community case management	4.Targeted communities across the country acquire positive behaviour and demonstrate enhanced demand for health services with a particular focus on the neonatal period.	5.Institutional capacities strengthened to plan and monitor for improved quality and equitable IMAM, IYCF and micronutrient services including during emergencies	6.Supported communities demand for and practice optimal nutrition and care practices for children, with particular focus on recognizing and treating severe acute malnutrition	7.Capacity of WASH institutions at National and regional levels strengthened to plan, deliver, and monitor WASH services for underserved populations, schools, and health facilities including during humanitarianism situations.	8.Caregivers and communities use safe drinking water and adopt adequate sanitation and good hygiene practices.