



Evaluation of RMNCH Trust Fund Activities

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BURKINA FASO

Evaluation Question 1: Relevance

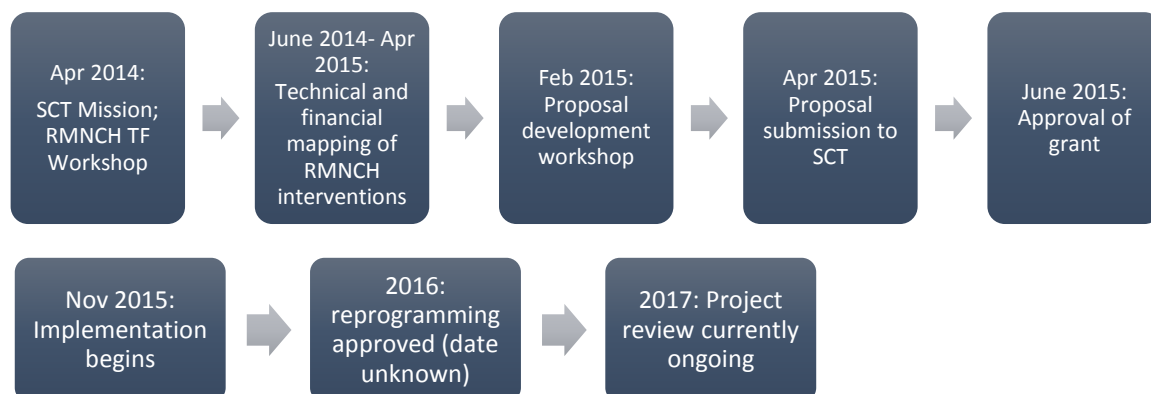
To what extent were the RMNCH Trust Fund global support and supported interventions at the country level clearly focused on addressing bottlenecks and gaps in RMNCH commodities, services and resources at the country level to accelerate achievement of MDGs 4 & 5?

In June 2015, Burkina Faso was awarded a grant from the RMNCH TF totalling \$5,088,424 for a period of one year. This was extended to October 2016, providing a total of 15 months for implementation.

The objectives for the grant are listed on the dashboard and focused on capacity development of clinical service providers and community health workers in RMNCH, strengthening RMNCH service environment, improving MDSR, supporting adolescent reproductive health and strengthening coordination.

The planning process in Burkina Faso began in 2014 when the SCT organized a workshop with the MOH, in-country UN agencies and other health partners to inform them about the TF and the CEP process (see timeline). It should be noted that Burkina Faso experienced civil unrest in October 2014 and a *Coup d'état* in September 2015 which had an impact on the country's ability to move forward on planned activities (see later under Factors Facilitating or Impeding Rapid Program Implementation).

Figure 1: Burkina Faso Timeline



Engagement of all stakeholders

As noted in the timeline, the CEP began with an introductory workshop from the SCT members. The subsequent process of identifying bottlenecks was perceived by key stakeholders as very participatory. All relevant MoH departments and divisions and the three UN agencies were actively involved in the design of the project. To some extent, the subnational level (Provincial Health Departments and District Health Teams) was invited to participate. However, it is less clear that other bi- and multilateral development partners participated actively in the CEP process. While documentation provides evidence that they were *invited* to different planning workshops and meetings, there is little proof of actual *participation*, and interviewed partners (USAID, GIZ, World Bank and MSI) do not recall having participated in any meeting regarding the CEP or project development. Exceptions to this are (1) the initial workshop moderated by the SCT in April 2014 (in

which several partners participated); and (2) providing information to the mapping exercise at the request of the consultant team.

Identification of Bottlenecks and Gaps:

As in most other countries, the two strategies used to identify bottlenecks and gaps were (a) programmatic and financial mapping of RMNCH interventions; and (b) a review of existing data and documentation on key gaps and bottlenecks in RMNCH. This was done with the assistance of consultants. Evidence indicates that the results of the mapping exercise were only partially used to develop the proposal. Key stakeholders, particularly the MOH, felt that it did not provide sufficiently detailed information on existing interventions, funding sources, and bottlenecks and gaps at regional and district levels. The final report of the mapping exercise was never formally validated by the MOH. The majority of stakeholders interviewed believed that the MOH should have provided more guidance to the consultants conducting this exercise to ensure that their needs were met. Only two stakeholders interviewed said that this mapping exercise was useful as a basis to prioritize interventions and develop the proposal.

The MOH proceeded with an additional analysis of bottlenecks and gaps based on existing strategies and plans which included the RMNCH Road map¹ and the National Health Development Plan (NHDP),² annual workplans and RMNCH indicators at district, regional and central levels, and the most recent EmONC Survey conducted in 2010.³ The additional analysis was used to select intervention zones based on the following criteria:

- Regions with high maternal and neonatal mortality rates and few partners/projects
- Complementarity with other partners to ensure a better geographic coverage (i.e. select districts not covered by H4+, Global Fund, Muskoka etc.)
- Regions and health regions in most need based on gaps identified in work plans and EmONC survey
- Priority was given to high impact interventions already part of routine activities and national plans and strategies

In addition, given the short duration of the project, the decision was made to focus on improving service access and quality, and not on demand creation. The mapping identified key programmatic areas for focus: screening for reproductive cancers, prenatal care, EmONC services, pneumonia and other respiratory infections among under-fives, diarrhea among children under-five, and micronutrient support.

Four intervention zones were identified based on these criteria and considerations: Boucle de Mouhoun, East, Centre, and Sahel.

Stakeholders affirmed that the funding proposal and implementation plan submitted directly addressed the needs and gaps identified during these processes. There is a clear match between the identified needs and proposed objectives in improving access and quality of EmONC services through training, equipment and supervision; and in strengthening clinical and community-based IMCI interventions to prevent and treat diarrhea, pneumonia, malaria and malnutrition among children under five. However, other objectives in the proposal were not directly linked to the funding gaps identified in the financial resource mapping. For example, both youth and adolescent health, and essential newborn care, appear to have had more funding than the estimated budget (according to

¹ Ministry of Health of Burkina Faso. Feuille de route pour la réduction de la mortalité maternelle et néonatale 2006-2015. Document de revue. April 2013.

² Ministry of Health of Burkina Faso. Le Plan national de développement sanitaire (PNDS) 2011-2020. 2011.

³ Ministry of Scientific Research and Innovation of Burkina Faso. Evaluation des Besoins en Soins Obstétricaux et Néonataux d'Urgence, couplée à la cartographie de l'offre de soins en Santé de la Reproduction au Burkina Faso. 2010.

the financial resource mapping), but were still prioritized and included in the TF proposal. This is because the MOH also drew on other sources of information to identify gaps and prioritize interventions as noted above. Also, because it was difficult to obtain precise information on available resources from partners, the funding gaps might not be accurate.

Funding Gap:

In the course of the mapping exercises, a total funding gap of approximately \$59 million was identified. The TF grant approved was \$5,214,838 (see Table 1)

Table 1: Burkina Faso: Funding Gap

RESOURCES NEEDED	AMOUNT
Estimated cost	\$177,361,123
Available budget	\$118,384,049
Funding gap	\$58,977,074
Trust Fund Grant	\$5,214,838
Remaining gap	\$53,762,236

There is no clear evidence to suggest that the remaining gap in funding was supported by other RMNCH partners or programs. Access to budget data for ongoing and new programs was not made available and when prompted, interviewees did not have an answer for this question. It is most likely that no additional funds were raised to fill the gaps (as in many other countries), as other partners were not involved in the validation or follow-up on the gap analysis and financial resource mapping exercise.

Evaluation Question 2: Effectiveness

How effectively were RMNCH Trust Fund supported grants implemented at country level?

To what extent was Trust Fund global and regional programming support available and utilized to facilitate effective implementation?

Disbursement Delays:

Burkina Faso experienced delays in disbursement of funds from WHO headquarters to the WHO country office. Due to the Ebola crisis, WHO West Africa Region did not have “sufficient budgetary space” to receive the funds, apparently a technical issue with limited space in the accounting system. This issue was resolved in November 2016. Evaluation respondents noted that use of an existing grant management mechanism called “*Programme d’appui au développement sanitaire*” (PADS)⁴ to channel funds through UNFPA facilitated fast and smooth disbursement of funds to implementing partners. Once the annual workplan was approved between UNFPA and PADS, there was no need for quarterly fund requests. Long or delayed procurement processes for some maternal and equipment delayed implementation. Some equipment was only delivered towards the end of 2016, early 2017, especially procurements under the reprogramming.

Factors Facilitating or Impeding Rapid Program Implementation:

The start of the implementation was delayed approximately 4-6 months due to socio-political instability and WHO procedures delaying the disbursement of funds to the WHO country office. Once implementation started, it seems that funds were disbursed smoothly to implementing

⁴ PADS is financed by the KfW, AFD, UNFPA and UNICEF. Ministry of Health of Burkina Faso. *Programme d’appui au développement sanitaire. Rapport d’activités 2014*. March 2015

partners (MOH departments at central level and regional health divisions) and that the different actors implemented their package of activities in an effective and timely manner. The major challenge was around long procurement processes and significant delays in distribution/delivery of material and equipment to health district and health facilities. This caused significant “sequencing” issues, as trainings took place long before the material and equipment arrived at facility level. A new community health strategy of recruiting and paying CHWs a monthly lump sum was delayed. Government recruitment of CHWs was slow resulting in delays in training of CHWs in home-based newborn and mother care. Evaluation respondents cited other factors facilitating or impeding rapid program implementation (see Table 2).

Table 2: Burkina Faso: Factors Facilitating or Impeding Rapid Programme Implementation

COUNTRY	FACILITATING	IMPEDING
Burkina Faso	<ul style="list-style-type: none"> • \$5 million grant was a significant “booster” • Appointment of MOH focal point to coordinate project • Appointment of WHO staff as lead facilitator • Strong engagement of MOH to implement in a timely/effective manner – motivated by potential to become GFF country • Responsiveness and smooth communication with SCT • Flexible response from TF to reprogram funds • MOH decision to transfer funds directly to regional health departments • Use of an existing UNFPA grant management mechanism • Availability of national and regional pools of trainers • UN agencies had prior experience with implementing joint projects (H4+, Muskoka Initiative, etc.) 	<ul style="list-style-type: none"> • Socio-political instability in 2014-2015; • Disbursement delays – see above • Lengthy procurement processes • Distributing equipment/material “the last mile” to health facilities • Delays in recruitment and training of CHWs; implementation of home-based ENC not yet started because training and equipment delivery took place very recently (e.g. Dedougou health district – April 2017) • Weak and irregular coordination between the three UN agencies during implementation. • Short duration of the Project, initial 4-month delay, and reprogramming late in the process, put actors under tremendous pressure to implement fast, conflicting with other priorities.

Programming Support:

The MOH and WHO focal points were in regular contact with the SCT and appreciated the regular communication through email and conference calls, and the responsiveness of the SCT. The MOH and the three UN agencies appreciated the TF flexibility in enabling reprogramming of funds. There was no evidence of TRT or other international technical assistance besides the SCT consultant who supported the resource mapping exercise.

Provider Capacity, Opportunity and Motivation to Provide Services:

Despite the short duration and the sociopolitical challenges, the Trust Fund contributed significantly to capacity development through training (see Table 3).

Table 3: Burkina Faso: Capacity Building

BURKINA FASO: TYPE OF TRAINING⁵	NO. OF INDIVIDUALS TRAINED
CEmONC training for clinical public and private service providers	125
BEmONC training for clinical service providers	534
Essential Newborn Care training for clinical public and private service providers	425
EmONC Monitoring tool training for providers at referral hospitals	90
EmONC and IMCI orientation for teachers of National Public Health School (training school for midwives and nurses)	30
EmONC and IMCI training for final year students at five National Public Health Schools	1250
Emergency Triage Assessment and Treatment (ETAT) training for providers at referral hospitals (425 planned)	191
Clinical IMCI for providers in three districts ⁶	24
Home-based Essential Newborn Care training for providers (reprogrammed activity)	391 clinical providers 1318 CHWs
Mentoring training	60

A mentoring approach was implemented to support continuous capacity development post-training. The sixty mentors trained conducted 240 mentoring visits to health facilities. Supervision was prioritized and included in the original proposal, recommended by the SCT. One joint supervision visit was conducted by the MOH and WHO. UNFPA and UNICEF were unable to participate due to conflicting schedules. The visited health districts and facilities noted that supervision visits are regularly conducted as part of DHMT routine tasks. No supervision visit reports were available to the evaluation team.

Objective two focused on increasing access to RMNCH commodities. Respondents were pleased with the overall quality of equipment and material provided, with a few exceptions, and stated that it had helped them to improve the quality of services. EmONC equipment was provided to referral hospitals; 459 health centres received newborn resuscitation equipment; contraceptives were provided by UNFPA; WHO provided two refrigerators to store blood in the referral hospital in Dori Health district. Quality assurance tools and IMCI clinical and community tools were reproduced and distributed. However, most of these accomplishments were significantly delayed. For example, UNICEF delivered the first batch of equipment and materials for essential newborn care (including newborn resuscitation kit) mid-2016, and distribution of the final batch was still on-going during the evaluators' field visit.

Forty-thousand blood bags were procured for distribution in Burkina Faso. Although the National Blood Transfusion Centre (NBTC) had been invited to provide technical specifications, due to a misunderstanding or unclear communication, WHO procured blood bags which cannot be used in Burkina Faso. The blood bags have not been distributed and the NBTC have requested WHO to provide replacements. The NBTC has "advanced" some blood bags with their own stock, but this may create a stock out towards the end of the year.

⁵ Source: RMNCH Trust Fund. 2014-2015 Final Report 2014-2015. December 2015

⁶ The original target was 515. Funds were reprogrammed to avoid duplication with Global Fund IMCI clinical trainings under the HSS grant.

During field visits to five health facilities, the evaluation team observed environmental factors that affect the “opportunity” for providers to deliver quality services. This was confirmed in the joint supervision report. These included:

- Demand for services has risen, primarily due to elimination of fees in 2016, and there are insufficient beds to accommodate the increased number of patients, particularly in the maternity wards and neonatal sections.
- Frequent stockouts of 13 LSCs (particularly amoxicillin, magnesium sulfate and oxytocin were frequently cited) which may be due to (a) increased demand in 2016; and (b) the socio-political crisis and mismanagement of the national procurement processes. It was noted that the procurement and supply chain management system in Burkina is generally well functioning and that stockouts were more frequent during the crisis.
- Some equipment and materials were stored in a warehouse upon receipt by the hospital director without informing the maternity ward or neonatal staff that they were available.
- Some equipment was inadequate or provided in insufficient quantities to meet demand. For example, tubes too large for newborns, resuscitation equipment not measuring temperature correctly, or too few delivery kits, and C-section kits.
- Providers and maintenance staff consistently raised a lack of training to use the equipment. For example, in one health centre, the auxiliary midwives did not know how to use newborn resuscitation equipment.

Providers and district and regional health teams lamented that they had not been asked to participate in the identification of needs and technical specifications. Quantification and procurement had been based on annual workplans which were most likely not entirely up to date by the time procurement occurred.

The evaluation team was unable to discern evidence of improvements in motivation. The World Bank RBF program is not operational in the health district visited (Dedougou). In addition, anecdotal evidence from the field visits indicate that motivation of community health workers is at risk because the government has not yet started paying the newly recruited community health workers.

User Capacity to Effectively Demand and Use RMNCH Services:

As noted earlier, the project primarily focused on the supply side, an explicit choice because of the significant gaps identified. In addition, stakeholders felt that one year was too short to change knowledge, attitudes and behaviours. There was little evidence on the existence of other demand-creation activities specifically for maternal and newborn health, as most partners and projects in the visited region focus on family planning, nutrition/breastfeeding and malaria. The planned training of CHW in home-based newborn and mother care was intended to support and inform women about danger signs during pregnancy and post-partum, but the activity was delayed/reprogrammed, and is only being implemented now in 2017, with other funding sources. The youth and adolescent component included sensitisation and demand creation activities, but had **very limited duration and reach** (60 group discussions held), and thus likely very little impact on attitudes and health seeking behaviours.

Evaluation Question 3: Efficiency

To what extent were the Trust Fund supported initiatives at country level implemented to achieve prioritized health goals and maximize resource utilization?

Coordination without Duplication:

Evidence suggests the RMNCH TF has been perceived and implemented as a temporary project with little or no effect on coordination and alignment of partners.

The evidence regarding the efficiency of the internal *coordination* of the Trust Fund grant is mixed. All stakeholders agreed that project coordination was efficient because “most activities were implemented on time and targets were reached”. The two focal points (MoH and WHO respectively) communicated regularly, and ensured timely communication with and reporting to the SCT. Key stakeholders (both UN and MoH) noted it had been extremely difficult to meet in person due to conflicting agendas. Project coordination was primarily ensured through email and phone, and was limited to collecting and compiling the different inputs for the annual reports or when the SCT requested a response. The UN agencies regret that they did not meet more often to share information and lessons learned among themselves and with the different MOH departments and divisions involved. The different objectives/components of the project seem to have been implemented in a vertical manner by different departments/divisions of the MoH, missing the opportunity to collaborate and integrate services across departments/divisions and UN agencies. At higher levels, MOH capacity to effectively lead and coordinate the TF grant across the different MoH departments and UN channelling agencies directly involved in the implementation of the grant (implementing partners) was weak. A number of factors influenced this leadership role: The MoH focal point, appointed at the end of 2015, was transferred from the Family Health Department to another department as Director in March 2016. He retained the focal point role throughout implementation, but was perceived to be less available and no longer reported to the Director of Family Health. The Director of Family Health changed in March/April 2016, resulting in less coordination and leadership of the TF initiative. The lack of high level coordination of the TF grant and its implementing partners should be seen in the light of a general challenge of weak coordination of the RMNCH sector.

Interviews with bilateral and multilateral partners suggest that while there is willingness and some effort to improve alignment, harmonization and coordination, there is still no joint planning, programming or monitoring/supervision of activities and the MOH has insufficient capacity to effectively align and coordinate the partners. Coordination among partners occurs mostly at the strategic and planning level (e.g. ensuring geographic coverage), but not at a detailed programming and implementation level.

On a positive note, some partners recognized that there have been increased efforts to coordinate their own efforts to avoid duplication. For example, both the Global Fund and UNICEF had planned activities to training CHWs in community IMCI and service providers in clinical IMCI. A key reason that this could occur is that the Family Health Division was apparently not part of the process to develop the Global Fund concept note pertaining to this activity. To avoid duplication, UNICEF cancelled these activities and reprogrammed the funds with approval from the SCT.

Sequencing of Activities:

As noted previously, there have been delays in procurements or training (see impeding factors above), and the two were not well sequenced to occur at the same time so that the trained providers had the necessary equipment and material to apply the newly acquired skills to their daily practice in the work place. The final report⁷ of the project states that planned ToT and training of CHWs in home-based essential newborn care in two regions (Boucle de Mouhon and East) had been completed 100%. The field visit to Dedougou revealed that the ToT had just been completed (2017)

⁷ TF country team in Burkina Faso. *Final Grant Performance Report Burkina Faso*. 28 April, 2017 (Excel sheet)

and the CHWs had not yet been trained. There is no clear explanation for this discrepancy, but it may be that UNICEF has used other funding sources in this particularly health district to implement or extend the training.

Responsiveness to national and sub-national needs

The TF was perceived as responsive to national priorities and needs because it filled significant gaps in RMNCH national plans. All stakeholders repeatedly and consistently highlighted the fact that the TF did not support new approaches, but rather supported existing and well-known high-impact interventions that were already included in those plans.

At the sub-national level, Regional Health Departments (RHD) and District Health Teams (DHT) also confirmed responsiveness to their needs, filling important RMNCH gaps as defined in their workplans. There was a difference of opinion between the central and regional/district levels about whether the sub-national level was invited to participate in planning for the grant and there is no evidence to determine which opinion is correct. The DHT attended an information meeting at central level after the grant had been approved. As noted above, they wished they had been consulted specifically about equipment/material needs.

Evaluation Question 4: Sustainability

To what extent is it likely that RMNCH results achieved with a contribution by the RMNCH Trust Fund will be sustained beyond the end of the Trust Fund through the availability of alternative funding sources (domestic or international) and continuous programming support?

Reach, Intensity, Duration to Sustain Services

As with all other countries, Burkina Faso found the duration of the project and of many activities too short to create a lasting impact on service provider practices.

Documentation of Lessons Learned:

There has been no documentation of good practices or lessons learned which is primarily due to the very short implementation period. The MOH is currently conducting a “review of the RMNCH TF project” funded by other sources, to document results and lessons learned of the TF experience in Burkina Faso.

Scaling up with Alternative Resources and Programming Support:

There was no clear indication of scaling up of activities or approaches supported by the TF. The project helped to fill gaps at a specific point in time, but there was no explicit exit strategy. MoH stakeholders perceived TF supported activities to be sustainable because they are part of their routine activities and integrated into their annual workplans. For example, the service providers who were trained and the new equipment are expected to last at least last for some years. However, continuous and sufficient financing of activities is not guaranteed (e.g. for refresher training, mentoring, regular supply of drugs, maintenance and replacement of equipment etc.)

The three UN agencies use their own funds to continue some activities in the same intervention zones supported by the TF (e.g. the UNFPA Thematic Fund and UNFPA Supplies, UNICEF funding for IMCI.) The MOH and UN agencies continue to seek new funding.

Integration of Unfinished Business into New Strategies and Plans:

Burkina Faso is not a GFF country, and there are no new large RMNCH projects in the pipeline. The TF-supported activities were primarily ongoing or existing core activities which were part of the national plans and will therefore continue beyond the TF.

Evaluation Question 5: Added Value

To what extent did the RMNCH Trust Fund and related processes contribute to an overall acceleration in progress toward achieving MDGs 4 & 5 in the programme countries. Was the Trust Fund support complementary and catalytic to other sources of investment in RMNCH?

Perceived Catalytic and Complementary Effects

The TF filled gaps, responded to immediate needs and was complementary to existing interventions, including Global Fund grants, USAID funding for FP and the H4+ JCPS which was implemented in other regions of the country. This is how stakeholders understood the project to be “catalytic.”

In Burkina Faso, there is no evidence that the project has had catalytic effects or contributed significantly to mobilization of additional resources or scaling up of good practices or approaches.

Perceived Acceleration of Improved Access:

Stakeholders perceived that the project has or will contribute to improved service availability. Service providers at district/health facility level felt that training and equipment had helped them improve their skills and ability to provide a better quality service: “it has definitely been an improvement as compared to before.” However, stakeholders unanimously noted that it is much too early to assess the added value or impact of the Trust Fund project on access, quality and utilization of RMNCH services (EmONC, IMCI, essential newborn care etc.), in particular as many activities were only implemented towards the end of the project.

The joint supervision visits to all project regions in December 2016 confirm that there has been no significant change in key indicators between 2014-2016.

Overleaf:

[Burkina Faso Dashboard](#)

BURKINA FASO

Country Context



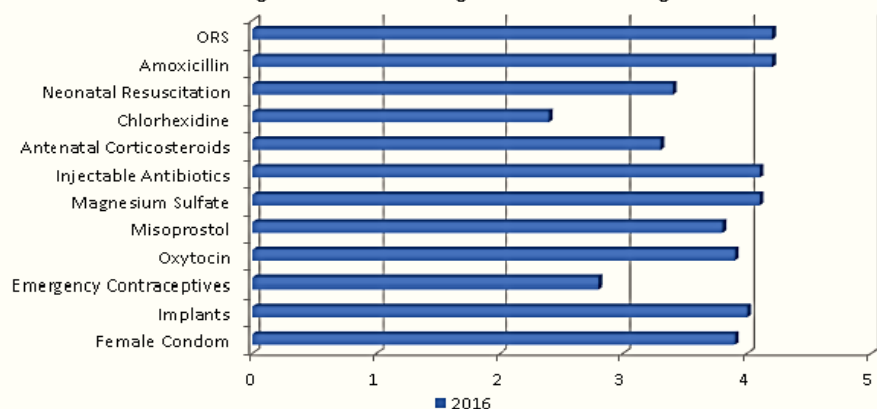
	2012	2015
Total population (000)	16,460	18,106
Total under-five population (000)	2,932	3,144
Total under-five deaths (000)	77	60
Under Five Mortality, per 1,000	102	88.6
Neonatal deaths (% of under-five deaths)	27	30
Neonatal mortality rate (per 1000 live births)	28	27
Infant mortality rate (per 1000 live births)	66	61
Total fertility rate (per woman)	5.7	5.4
Maternal Mortality Ratio, per 100,000 live births	400	371

Landscape Synthesis Reports

Average Performance Rating by Commodity-specific Indicator



Average Performance Rating for the 13 Life-saving Commodities



Objectives & Activities

Round 2

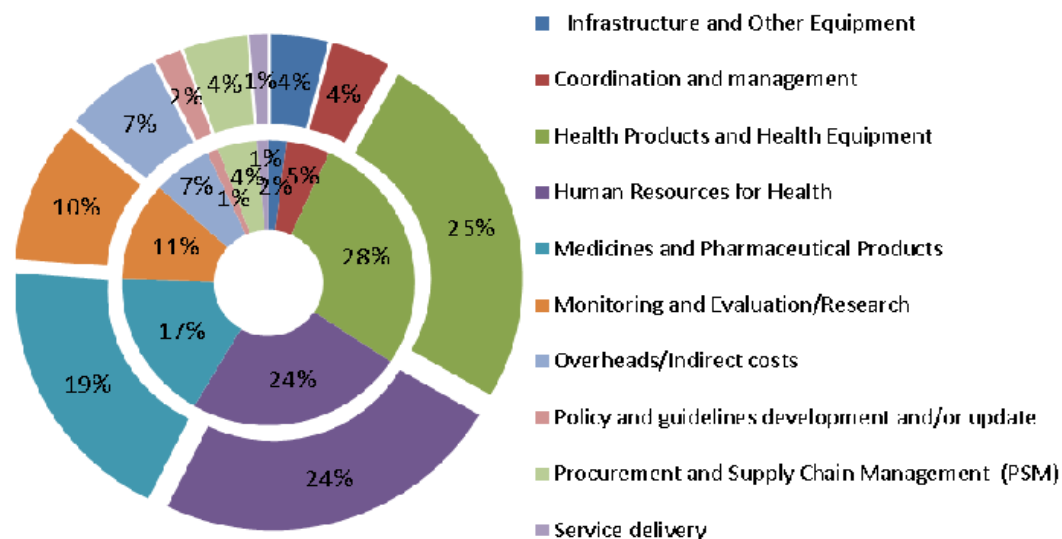
- ✓ Strengthen the capacity of service providers in EmONC, IMCI and essential newborn care at health facility and community level
- ✓ Improve the availability of RMNCH products, materials, equipment and management tools
- ✓ Improve maternal and neonatal death surveillance and the availability of data on adolescent health.
- ✓ Support the supply of youth-friendly SRH services in three health districts
- ✓ Strengthen the coordination and M&E of RMNCH interventions at central and deconcentrated level.



Total Budget VS Total Expenditure

Outer Circle: Total Expenditure, Inner Circle: Total Budget

Total Budget: \$5,088,425 Total Expenditure: \$5,076,817



Channelling Agencies Implementing Partners

UNICEF
UNFPA
WHO



MOH, UNICEF,
WHO, UNFPA

DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

Evaluation Question 1: Relevance

To what extent were the RMNCH Trust Fund global support and supported interventions at the country level clearly focused on addressing bottlenecks and gaps in RMNCH commodities, services and resources at the country level to accelerate achievement of MDGs 4 & 5?

Beginning in 2013, the DR Congo received three grants from the RMNCH TF as follows:

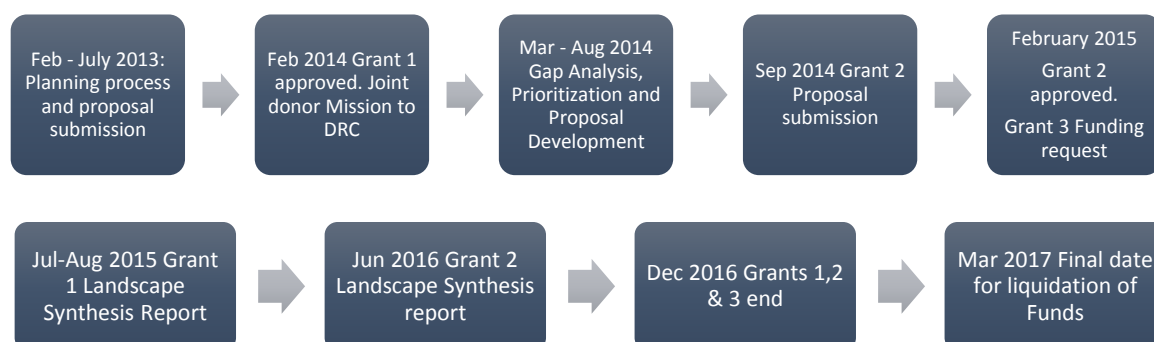
Table 4: DRC Grants

Overview of grants						
Grant	Focus	Channelling Agency	Implementing Partners	Period	Budget	Alignment
1	<u>Preparatory phase:</u> Remove key bottlenecks and prepare phase 2	<ul style="list-style-type: none"> • UNFPA • UNICEF • WHO 	<ul style="list-style-type: none"> • MoH • PSI 	2013-2016	\$3,496,404	<ul style="list-style-type: none"> • PNDS 2011-2015/CAO4&5
2	Improve access to 13 commodities Strengthen coordination at intermediary level	<ul style="list-style-type: none"> • UNICEF • WHO 	<ul style="list-style-type: none"> • MoH 	2014-2016	\$15,000,000	<ul style="list-style-type: none"> • PNDS 2011-2015/CAO4&5 • CEP Alignment Note and joint development plan • MOU for harmonisation of intervention package
3	Family Planning (commodities, capacity development) MDSR	<ul style="list-style-type: none"> • UNFPA • WHO 	<ul style="list-style-type: none"> • MoH 	2015-2016	\$7,999,320	<ul style="list-style-type: none"> • PNDS 2011-2015/CAO4&5 • National FP Strategy

The objectives for the three grants are listed on the dashboard. The first two grants primarily focused on strengthening both supply and demand for the 13 LSCs, as well as strengthening the national and provincial capacity to coordinate, monitor and evaluate the implementation of the DR Congo's MDGs 4 & 5 Acceleration Framework (*Cadre d'Acceleration des OMD 4&5, CAO4&5*) which was finalized in 2012 and launched in May 2013 by the National Health Sector Committee (CNP-SS). The primary focus of the third grant was to improve access to FP and to introduce and implement the Maternal Death Surveillance and Response (MDSR) approach.

The planning process for the RMNCH TF took place between February and July 2013 and resulted in the "National Plan to Remove Bottlenecks Related to the 13 commodities which save the life women and children". Figure 2 shows the timeline of events from February 2013 to March 2017.

Figure 2: DRC Timeline



Engagement of all stakeholders:

For grant 1, the MOH led a participatory planning and prioritization process which involved several (but not all RMNCH stakeholders) including WHO, UNFPA, UNICEF, USAID/MSH, ASF/PSI. They constituted the technical working group (TWG) for the 13 commodities which became the coordinating mechanism for the implementation of the grants. For grant 2, the TF provided technical and financial support to the CEP. RMNCH partners participating included MOH, USAID/MSH/PROSANI, Belgian Cooperation, French Cooperation, UNICEF, UNFPA and WHO. Grant 3 was an “add-on” to grant 2 when it was realized that there was an urgent gap in FP commodities which had not been accounted for in the grant 2 planning process. (The National Multisectoral FP Committee was not involved in the CEP/grant 2 planning process, except for UNFPA and the National Reproductive Health Program (PNSR). Grants 2 and 3 were consolidated into one grant.

Identification of bottlenecks and gaps:

Under grant 1, key bottlenecks and gaps were identified based on existing national data and information including governance, availability of the 13 LSCs and specific bottlenecks linked to each of them, M&E and research data, and financial barriers to access. In grant 2, the CEP process led to further identification of key bottlenecks and gaps in RMNCH commodities. At the same time, the focus was broadened to include governance and coordination for RMNCH, including support for staff at the national and provincial health coordination committees, and coaching for the newly created provincial health departments. As noted above, in 2015 a major funding gap was identified for contraceptive commodities at the national level and grant 3 focused primarily on procurement and distribution, FP capacity development, and supporting the implementation of the MDSR in Kwango Province.

Funding gap:

During the CEP process in 2014, the major RMNCH funding sources were the Global Fund, the World Bank, USAID, DFID and the European Union (EU). The total population in the country at that time was 28.25 million. The funding gap identified to support RMNCH services in 174 health zones (in coordination with the Global Fund) is described in Table 5:

Table 5: Funding Gap identified during CEP 2014

RESOURCES NEEDED	AMOUNT
Estimated cost	\$110,500,000
Available budget	\$32,700,000
Funding gap 2014	\$77,800,000
Trust Fund Grant 2	\$15,000,000
Trust Fund Grant 3	\$7,999,320
Remaining gap	\$54,800,860

It is not entirely clear to which extend the remaining gap (not filled by the RMNCH Trust Fund) was filled with other sources. According to the SCT annual report 2015, “Other partners including The World Bank, the Global Fund, and UNICEF were identified to support another \$69 million (49%). The remaining \$57 million would be prioritized for other potential funding sources as no source was readily identified during the Country Engagement Process.” However, key informants state that the World Bank, UNICEF and Global Fund funds had already been accounted for when doing the resource mapping, and that the Trust Fund was the only partner who contributed to filling the gap identified during the CEP process. The numbers given in the SCT annual report 2015 do not match with the numbers given in the MoH PowerPoint presentation. The latter has been used to report on financial numbers in Table 5 above. A key stakeholder note that the objective to scale-up the CAO4&5 to 109 additional health zones (outcome of the CEP process) was *not* achieved due to lack of resources, i.e. the identified funding gap was not filled.

Evaluation Question 2: Effectiveness

How effectively were RMNCH Trust Fund supported grants implemented at country level?

To what extent was Trust Fund global and regional programming support available and utilized to facilitate effective implementation?

Disbursement delays:

Implementation of grants 2 and 3 was significantly delayed, with many activities being implemented towards the end of 2016. There were delays in fund disbursement from the global level to the channelling agencies in country. Actual receipt of the second disbursement was delayed due to an accounting error and the funds were not identified by the UNICEF country office. (This also occurred in Malawi.) Initial disagreement between the MOH and channelling agencies about procedures (payment of per diem) was resolved when the Minister of Health became directly involved through his *Chef de Cabinet*. Differences in administrative procedures of WHO, UNICEF and UNFPA also cause delays, and implementing partners had difficulties understanding the different procedures of the H4+ agencies. A three-day workshop was organized by the MOH to harmonize procedures and implementation processes for the RMNCH TF grants.

In country, there were delays in disbursements between channelling agencies and implementation partners due to slow procurement processes. PSI had to pre-finance its work supported by UNFPA because of delays in signing the agreement.

Factors facilitating or impeding rapid program implementation:

WHO was slow to recruit staff for coaching provincial health departments, and for the provincial health coordinate committees. The design and production of MDSR tools took much longer than expected which left little time for actual distribution and implementation.

Under grant 1, the communication and social marketing campaign was not completed until towards the end of 2016. This was the only operational research/planning/design of the campaigns. At the time of the field visit, the implementation of the campaigns had not yet taken place.

Family planning training took place in the last quarter of the program – December 2016 to February 2017 – because the contraceptives procured under grant 1 did not become available until then. Procurement took almost one year, which is standard within the UNFPA system, but challenging when the timeframe of the overall project is so short or when there is an emergency need for commodities. In March 2017, the PNSR had still not received training reports from provinces and health districts because

the trainings had “just taken place.” Overall, there had been a lack of time and funds for post-training supervision in family planning.

Table 6: DRC: Summary facilitating and impeding factors

COUNTRY	FACILITATING	IMPEDING
D. R. Congo	<ul style="list-style-type: none"> • Strong MOH leadership at the highest levels (Minister of Health through “<i>Chef de Cabinet</i>”) • Technical committee organized regulator coordination and monitoring meetings • H4+ integrated themselves into government-led coordination platform • Efficient and flexible programming support from the SCT • Existence and experience of the H4+ partnership platform • Context conducive to improved coordination and alignment – willingness among key partners to harmonize approaches, align to national priorities and improve complementarity 	<ul style="list-style-type: none"> • Fund delays meant short implementation • Design and production of MDSR tools took longer than expected – little time for distribution and implementation • Lengthy process for contraceptive procurement – almost one year • FP training took place in the last quarter of the program (Dec 2016-Feb 2017) • Lack of time and funds for post-training supervision in FP

Programming support:

Respondents reported strong programming support from the SCT regarding grant management, planning and monitoring. However, there was little evidence of support from the TRT. Most stakeholders were not well informed about the TRT. Some stakeholders were aware of globally produced guidelines and confirmed receipt of those by email, but they were unclear whether these were from the TRT or general knowledge products from their headquarters. PSI confirmed having been informed about the community/awareness-creation online resource platform established by the TRT but had not used it. The MOH indicated that they had requested TA to support local production of drugs but had not received a response.

Provider Capacity, Opportunity and Motivation to provide services:

Capacity development was not supported in any substantial way, except for training CBD agents and clinical services providers in FP under grant 3. This was primarily because other programs, particularly H4+, USAID/PROSANI, Tulane University, Pathfinder and others were already heavily invested in supporting capacity development in EmONC, IMCI, PMTCT, and FP. Training was therefore not identified as a priority during the CEP process. During field visits, health workers confirmed having been trained by other RMNCH partners and felt that this had improved skills and capacity to provide a better service for pregnant women, newborns and children.

In FP, a major achievement was that tools for CBD agents were translated into local languages for the first time.⁸ As noted above, training of health facility workers did not take place until the last 3 months of the grant because the contraceptive supplies were not yet available. For the MDSR, the logframe reported that all providers, health zone teams and provincial health departments in Kwango Province

⁸ Source: Annual Report Grant 2-3, 2014-2015, p4

had been oriented to the use of these tools. However, during field visits to a health facility in Kenge health zone, it was evident that the tools had just been deposited a few days before the team's arrival and the health staff were not informed about their use and had not yet begun applying the process. Key stakeholders at the sub-national level (provincial health departments and health facilities) regretted that the TF did not support post-training supervision or mentoring because the time was too short and it had not been taken into consideration. In addition, at the sub-national level, staff reported that they had not been trained to use some of the equipment provided e.g. echography delivered by PESS, UNFPA and KOICA to the general referral hospital in Kenge.

RMNCH commodities, material and equipment were provided by the TF and other partners. Respondents during field visits noted that there had been challenges with transportation of Family Kits from health facilities to the community provision points. CHWs had no means to pay for transportation and had to walk long distances with the kits on their heads to get them to the villages. In addition, a frequent concern was the lack of water and electricity which negatively affects the quality of services as they cannot use certain materials and equipment e.g. oxygen concentrators require electricity.

Low motivation among health workers is very common. Seventy per cent are not on payroll, resulting in unregulated high user fees.⁹ The World Bank-supported Results Based Financing (RBF) program is also being implemented in the zones where the TF operated, provided incentives to increase motivation of both health workers and CHWs. On the positive side, health workers confirmed that training increased their motivation because they felt more confident delivering a quality service and could see the results: haemorrhages stopped, well-performed c-sections, etc.¹⁰

User Capacity to Effectively Demand and Use RMNCH Services:

CHWs were supported to sensitize families about danger signs and to provide and support the use of family kits. Communications and social marketing campaigns around the 13 LSCs as part of grant 1 were designed, but not implemented because they were not included in grant 2 because of other priorities.

Central to the CAO4&5 plan, was the distribution of the Family Kits Approach. The kits provide households with medications to control diarrhoea and fever, a prenatal consultation kit for pregnant women, and a kit containing the essential inputs necessary for deliveries without complications. Included in the kits were subsidized vouchers linked to a flat-rate pricing strategy to enable women to access services for themselves and their families. During field visits to Kenge, it was evident that the support for sensitization and demand-creation for the Family Kit Approach was inadequate. Families did not have the correct knowledge and attitudes to use the multi-micronutrients, using one bag for several children, or using them as spice to make food taste better.

A feasibility study on the inclusion of the 13 LSCs in the scheme was conducted, but not followed up, although the reasons why are unclear and the PNPMS is still searching for funding to support this. Drugs provided by the RMNCH TF were provided free of charge.

There was insufficient awareness of FP among users. The service providers have been trained and commodities are available now, but there is a need to intensify awareness campaigns.

¹⁰ Source: field visit to Mbanza-Ngungu and Mosango during H4+ field mission

Evaluation Question 3: Efficiency

To what extent were the Trust Fund supported initiatives at country level implemented to achieve prioritized health goals and maximize resource utilization?

Coordination without duplication:

As noted previously, the TWG for the 13 LSCs was established under the leadership of the Minister of Health's *Chef de Cabinet*. It was headed by directors of two departments (Family Health, and Medicines and Pharmacy), in collaboration with the Department of Planning and Studies, Department of Community Health Funds, and the National RH Program. The committee was supported by two technical staff and held bi-weekly meetings in the beginning, reducing to quarterly and ad hoc as the program progressed. Respondents felt that this process contributed to strengthening inter-ministerial collaboration. It was noted that going forward, once the TF ends, this committee will be integrated into the existing sub-committee for medicines under the National Technical Coordination Committee of the National Health Sector Coordinating Committee.

Since 2014, respondents noted that coordination and alignment of RMNCH partners has significantly improved and the TF contributed significantly to “boosting” alignment and coordination of partners. Participatory processes helped to increase awareness of RMNCH partners of the importance of the 13 LSCs and of the bottlenecks and gaps that prevent women and children from accessing these commodities. The CEP led to increased awareness and greater alignment of partners to the CAO4&5; a consensus workshop for all partners and a financial gap analysis of 174 health zones in 2014; signature of an alignment note by several RMNCH partners and development of a joint workplan for 2014-2015 to expand coverage of the Cao4&5; and establishment of a donor driven virtual platform for RMNCH coordination and harmonization. However, not all partners participated in TF/CEP processes e.g. KOICA, JICA. UNICEF and SANRU (Global Fund PR) are distributing commodities jointly to the health zone level under the aegis of an MOU signed to facilitate joint distribution.

Programs continue to be implemented in a vertical manner, and while the RMNCH TF coordinating committee mainly focuses on strategic issues, coordination at the operational level is weak. Field visits to the Kenge health zone revealed a lack of responsiveness to local needs. For example, RMNCH equipment was delivered by several partners to the general hospital without prior consultation with the beneficiaries. There is a lack of coordination over pricing of medicines: patients must pay for essential medicines provided by KOICA, while the same medicines are provided free of charge through the TF. Ambulances were delivered without prior discussion among the partners.

Sequencing of activities:

Respondents identified several challenges in the sequencing of activities. CBD agents were training in FP quite some time before the health facility providers who supervise the CBD agents were trained. MDSR tools were received, but training has yet to be provided on how to use them, based on field visits. Demand creation activities have been insufficient or delayed. Transportation to enable CHWs to deliver Family Kits was not considered in advance, and electricity and water are not reliably available.

Responsiveness to national and sub-national needs

Respondents agreed that the TF was strongly aligned to national strategies and plans (PNDS 2011-2015 and CAO4&5). Grants 2 and 3 were specifically based on the six key strategies of the CAO4&5. However, as noted above, TF responsiveness to sub-national needs was less evident. Planning done at the central level, did not always adequately account for the realities of implementation at the sub-national level. Activities supported by TF and other partners are often vertical and not necessarily integrated into the annual work plans of the provinces and health districts.

Evaluation Question 4: Sustainability

To what extent is it likely that RMNCH results achieved with a contribution by the RMNCH Trust Fund will be sustained beyond the end of the Trust Fund through the availability of alternative funding sources (domestic or international) and continuous programming support?

Reach, Intensity, Duration to Sustain Services

As in most countries, respondents found that the duration of the TF support was too short to create a lasting impact on skills and competencies of service providers. Nonetheless, achievements in regulations, norms, and standards, as well as training modules and tools for FP and MDSR are national documents which will continue to be used by the MOH and other partners.

Documentation of Lessons Learned

The short duration of the TF was given as a reason for lack of documentation and there is little evidence that it was planned. It was mentioned that the MOH needs capacity development to lead documentation, dissemination and knowledge management processes. Some initiatives are underway to document certain approaches e.g. coaching, MDSR experience, Family Kit Approach.

Scaling Up with Alternative Resources

Some agencies continue to make efforts to extend existing funds or to mobilize new funds to support continuation of TF-supported activities:

- PSI – has integrated activities to implement the social marketing and communications campaigns designed with TF resources into other programs and they are currently negotiating with UNFPA to fund part of the campaign.
- TF/WHO supported the training of twelve Provincial Health Departments (PHD) and one health zone in each of the 12 PHDs in the MDSR. The PHD now continue to train other health zones. Other partners are now also using the tools to scale up. However, the needs are enormous – 516 health zones.
- GAVI and European Union – will fund the coaching approach in 8 out of the 12 PHDs previously supported by the TF. Japanese funding through the World Bank will support this in one additional PHD.
- Stakeholders felt that the achievements of the Trust Fund grants have shown the importance of family planning and encouraged the government to commit these funds. H4+ joint advocacy efforts and increased political support for RMNCH led to the government committing to purchasing contraceptives: the government has included a budget line for contraceptives in the national budget” (3.5 million USD annually). In 2015, 300,000 USD were allocated, and in 2016, it was 1 million USD.
- The collaboration platform and the “complementary financing” of a standard RMNCH package by the RMNCH Trust Fund, GAVI, the Global Fund, UNICEF, the World Bank, UNFPA and USAID is a key achievement in alignment and scaling-up key RMNCH interventions in the DRC. This also includes the family kit approach: *“In the DRC, complementary financing from the RMNCH Fund, jointly with UNICEF, the Global Fund, GAVI, the World Bank and other bilateral partners, has made possible the scale-up iCCM across large parts of the country. The Fund supported essential commodities included in the ‘family kits’, distributed through Community Health Workers. (...) RMNCH Fund resources have had a catalytic effect. For example: in the DRC, co-financing with the Global Fund, GAVI, the World Bank has multiplied the Fund’s investments dramatically.”*¹¹

¹¹ Source: Strategy and Coordination Team. 2015 Progress Report. Feb 2016, p. 4

Integration of Unfinished Business into New Strategies and Plans

Key stakeholders believed that the GFF and the World Bank PDSS (RMNCH/RBF) program would continue to support TF-supported interventions. World Bank additional funds (\$30 million) will be used to support FP and FP indicators have been included in the RBF list of indicators. Strengthening the supply chain is also included.

- UNICEF – will sustain delivery of Family Kits to 43 health districts but new funds will be needed.
- UNFPA – will continue to supply contraceptives with other funding sources (UNFPA Supplies Program)
- National Health Development Plan (PNDS) 2016-2020: Strengthened joint advocacy undertaken by the H4+ partners during the H4+ and RMNCH Trust Fund implementation influenced the development of the National Health Development Plan (PNDS) 2016-2020 and resulted in a much stronger focus on RMNCH than the previous PNDS 2011-2015
- All CAO4&5 interventions have been integrated into the new PNDS 2016-2020
- GFF: According to MoH and H4+ partners, the key strategies and approaches implemented under the CAO4&5 have all been integrated into the GFF investment case, which will guarantee the sustainability of the achievements of the CAO4&5 and the Trust Fund. The GFF will support the direct continuation of the CAO4&5.
- The H4+ team contributed to the development of the GFF investment case to make sure that a bridge is created between H4+/Trust Fund and the GFF. Areas which were not sufficiently prioritized or funded under the H4+/Trust Fund have been given a higher priority in the GFF, e.g. nutrition and adolescent health.
- However, a monitoring mission report by the SCT indicates that not all important aspects of RMNCH have been integrated into the GFF, and recommended to the MoH and H4+ partners that they find other ways of sustaining/mobilizing funds for these areas.

Evaluation Question 5: Added Value

To what extent did the RMNCH Trust Fund and related processes contribute to an overall acceleration in progress toward achieving MDGs 4 & 5 in the programme countries. Was the Trust Fund support complementary and catalytic to other sources of investment in RMNCH?

Perceived Catalytic and Complementary Effects

The TF played a significant role, primarily through the CEP process, in contributing to a stronger commitment and alignment of RMNCH partners to the CAO4&5. The most significant result is the TF contribution to the development and scale-up of the Family Kit Approach to 43 health zones which has encouraged other partners to invest resources for the approach in other provinces and health zones. The EU will reportedly continue to support the implementation of coaching for the PHDs.

The Trust Fund, through the CEP process, “boosted” the joint collaborative efforts of UNICEF, Global Fund, World Bank, GAVI, UNFPA and USAID to support the implementation of a *harmonized and aligned* RMNCH package of interventions (i.e. manifested through the signature of the MOU), but this cannot be attributed to the Trust Fund alone, as it was an on-going parallel process, with strong linkages to the Trust Fund processes. TF support led to the development of the Landscape Synthesis Report, the alignment note, and the joint action plan 2014-2015, which were all intended to scale up CAO4&5.

It was not possible to obtain precise data on how much *additional funding* was mobilized as a direct result of the CEP process or the Trust Fund approach.

Perceived Acceleration of Improved Access

Anecdotally, during field visits, service providers stated that training (supported by other partners) and availability of material, equipment and commodities, including the Family Kits, had significantly

improved their capacity to deliver quality services. They perceive that the Family Kit Approach has helped to strengthen the trust and relationship between communities and health facilities; that vouchers have increased the use of commodities and services by reducing financial barriers and ensuring regular provision of drugs at community and health facility level.

At the central level, stakeholders perceived the TF's focus on regulation (norms, standards and tools related to the 13 LSCs) to have filled a significant gap which other partners had not focused on. Additional significant systems strengthening initiatives included, updating, reproducing and distributing RMNCH norms and standards, supporting the introduction of MDSR, and coaching support to PHDs. Stakeholders noted, however, that a much longer implementation period and additional resources are required to sustain these positive achievements: to strengthen the MOH capacity to coordinate effectively, operationalize the MDSR, strengthen the capacity for service provision, including ongoing supervision and mentoring, and regular provision and maintenance of material, equipment, drugs, including water and electricity supplies.

Data on Utilization:

HMIS data in the DRC is unreliable. However, some data collected from the general referral hospital and two centres during field visits to Kenge show increases in use of services between 2014-2016:

- Assisted deliveries have decreased at the hospital and c-sections have increased. The number of deliveries at the referral hospital was reduced from 1135 in 2014 to 426 in 2016.¹²
- Assisted deliveries and focused ANC have increased at the health centres. The number of deliveries at one health centre increased from 27% to 67% between 2014 and 2016. In a second centre, the number percentage increase was from 81% to 82%.¹³ There have been no significant changes in FP services, perceived to be because of the lack of demand-creation.

Respondents suggested that the reasons for these changes is the strategy to ensure that women first visit health centres for assisted delivery, and the health centre will refer to the hospital for c-section and other EmONC services, if she is to benefit from the subsidized prices.

Overleaf:

[DRC Dashboard](#)

¹² Source: Évolution du nombre des accouchements à l'Hôpital Général de Kenge de 2013 à 2016. Direction de Nursing de l'Hôpital Général de Kenge

¹³ Source: Données des rapports annuels 2014, 2015 et 2016 du Centre de Santé

Democratic Republic of Congo

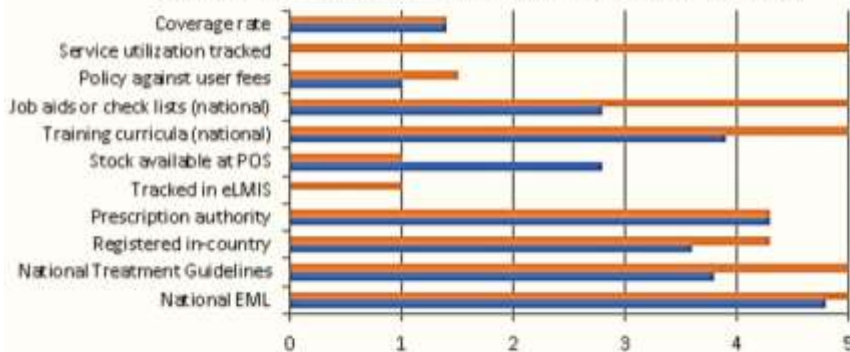
Objectives & Activities

Country Context

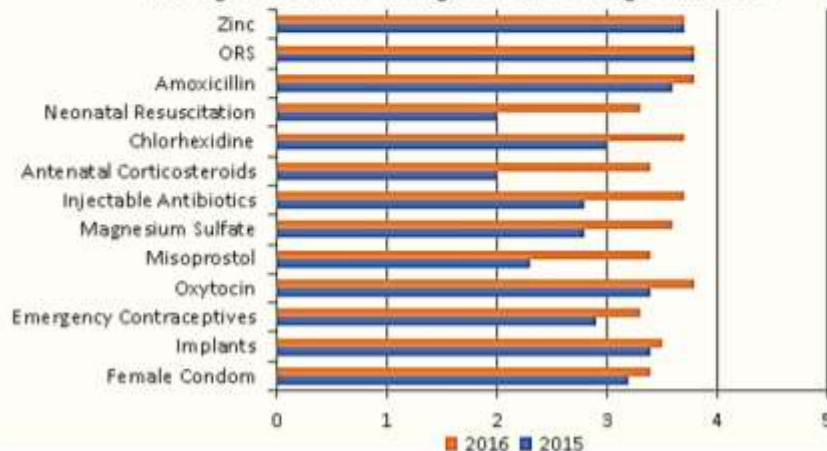
	2012	2015
Total population (000)	65,705	77,267
Total under-five population (000)	11,691	13,876
Total under-five deaths (000)	391	305
Under Five Mortality, per 1,000	146	98.3
Neonatal deaths (% of under-five deaths)	30	31
Neonatal mortality rate (per 1000 live births)	44	30
Infant mortality rate (per 1000 live births)	100	75
Total fertility rate (per woman)	6.0	5.9
Maternal Mortality Ratio, per 100,000 live births	730	693

Landscape Synthesis Reports

Average Performance Rating by Commodity-specific Indicator



Average Performance Rating for 13 Life-Saving Commodities



Round 1	Round 2	Round 3
<ul style="list-style-type: none"> ✓ Strengthen regulation of medicines, including 13 LSCs ✓ Strengthen quality control of medicines, including 13 LSCs ✓ Produce and distribute norms and standards related to RMNCH and 13 commodities ✓ Strengthen local production of medicines ✓ Develop a generic communication campaign for 13 LSCs and a social marketing campaign ✓ Strengthen M&E of interventions ✓ Reduce financial barriers to access ✓ Remove bottlenecks related to utilization of chlorhexidine, magnesium sulphate and oxytocin ✓ Improve knowledge and legislation for female condoms, implants and emergency contraception 	<ul style="list-style-type: none"> ✓ Ensure regular access to 13 LSCs through procurement and distribution to health facilities, community distribution points, and households ✓ Strengthen national and provincial capacity to coordinate, monitor and evaluate the implementation of the CAO4&5 through support to national and provincial CNP-SS and coaching of Provincial Health Departments ✓ Ensure regular access to FP commodities ✓ Improve quality of FP services ✓ Implement MDSR system in Kwanto province (14 health zones pilot) 	<ul style="list-style-type: none"> ✓ Ensure regular access to FP commodities (procurement and distribution to ensure regular provision of contraceptives to health facilities and CBD) ✓ Improve quality of FP services (training and supervision of clinical and community service providers)

Total Budget VS Total Expenditure

Outer Circle: Total Expenditure, Inner Circle: Total Budget

Total Budget: \$25.954.695 Total Expenditure: \$24.487.289



Channelling Agencies

UNICEF
UNFPA
WHO



Implementing Partners

MOH, UNICEF,
WHO, UNFPA,
PSI/ASF

MALAWI

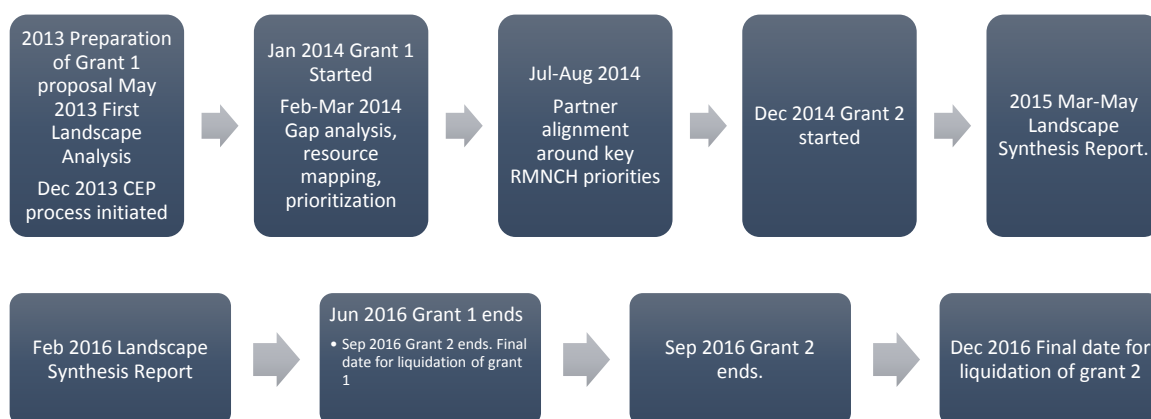
Beginning in 2013, Malawi received two grants from the RMNCH TF as follows:

Table 7: Malawi: Grant information

GRANT	REQUESTED AMOUNT
Proposal to strengthen access and utilization of RMNCH Commodities with Focus on the 13 Overlooked Commodities	\$3,992,220
Accelerate the reduction of maternal and neonatal morbidity and mortality towards the achievement of the MDGs 4&5	\$7,597,000

The objectives of the two grants are listed on the dashboard. The primary focus of the first grant was to address the 13 underutilized LSCs at the national level. The second grant was targeted towards documented gaps in RMNCH service delivery at facility and community levels and targeted 12 districts with poor maternal, child and neonatal indicators.

Figure 3: Malawi: Timeline 2013-2016



Evaluation Question 1: Relevance

To what extent were the RMNCH Trust Fund global support and supported interventions at the country level clearly focused on addressing bottlenecks and gaps in RMNCH commodities, services and resources at the country level to accelerate achievement of MDGs 4 & 5?

Engagement of all Stakeholders

For grant 1, the project was implemented by a consortium of partners, led by the Ministry of Health, and including Clinton Health Access Initiative (CHAI), John Snow International (JSI), Malawi Health Equity Network (MHEN) and UNICEF. The Reproductive Health Directorate (RHD) led the Steering Committee which brought together these partners, USAID, WHO, UNFPA, and UNICEF. The Steering Committee was answerable to two technical working groups: the Sexual and Reproductive Health Technical Working Group and the Drugs and Medical Supplies Technical Working Group.

For grant 2, in addition to these previous partners, the TF deliberations included Parent and Child Health Initiative (PACHI), Management Sciences for Health (MSH), Liverpool School of Tropical Medicine (LSTM), Save the Children International, and Mai Khande. GIZ also participated initially. The RHD continued in its coordination role. Partners continued to participate throughout implementation, and this created a forum for coordinated implementation that extended beyond project partners.

Identification of bottlenecks and gaps:

The project was planned with the objective of improving access for women and children to an uninterrupted supply of RMNCH essential commodities at all levels of the health system (28 districts) of Malawi. Key documents for both grants for identification and prioritization of gaps included the RMNCH portion of Malawi's "Vision 2020", the 2011 -2016 National Sexual and Reproductive Health and Rights Strategy, the 2011-2016 Health Sector Strategic Plan (HSSP), the Child Health Strategy for Survival and Health Development of Under-Five Children 2014-2020, the National Road Map for Accelerating Reduction of Maternal and Newborn Morbidity and Mortality developed in 2012, and the 2010 Demographic and Health Survey.

For grant 1, in this initial round, partners were invited to participate in prioritization processes based on their perceived expertise in addressing issues to increase access to and use of the 13 LSCs. The focus was predominantly national, and so engagement at the sub-national level was limited to gathering data.

For grant 2, the project was targeted towards well-recognized gaps in service delivery at facility and community levels. The planning and budgeting processes were led by the Director for Policy and Planning. A gap analysis was conducted in 2014 with the assistance of a consultant, along with resource mapping and prioritization of interventions. The gap was much wider than the resources known to be available from the TF and so the steering committee selected 12 target districts based on maternal and child death burden: Blantyre, Dedza, Dowa, Kasungu, Lilongwe, Mangochi, Mchinji, Mulanje, MzimbaNtcheu, Thyolo and Zomba.

Funding Gap:

During the CEP process in 2014, the committee reviewed estimates for priorities in family planning, maternal health, neonatal health and child health, as well as existing resources available to address those priorities and came up with a funding gap of \$31,200,471.

Table 8: Malawi: Cost Estimates and Funding Gap for RMNCH Priorities¹⁴

RESOURCES NEEDED	ESTIMATED COST \$	FUNDS ALLOCATED \$	FUNDING GAP \$
Family Planning	4,378,890	2,000,557	2,378,333
Maternal and Newborn Health	14,392,571	1,392,571	13,000,000
Child Health	13,317,500	8,500,000	4,817,500
Referral System Strengthening	2,000,000	-	2,000,000
iCCM (delivery costs)	3,320,809	301,891	3,018,918
Nutrition	5,000,000	569,333	4,430,666
PIMHSM	400,000	-	400,000
District Health Performance Improvement	6,000,000	6,000,000	0
Monitoring and Evaluation	1,353,944	198,890	1,155,054
TOTAL	50,163,714	18,963,242	31,200,471

In the final report of grant 2, it was noted that the TF served as a catalyst that stimulated harmonized implementation of related interventions by various partners, including those not participating in the project, and an increased focus on RMNCH. It also formed the basis for activities to mobilize additional resources.¹⁵ Evaluation respondents noted that TF resources were insufficient to bridge the gaps

¹⁴ Source: Malawi RMNCH Priorities, Costs and Funding Gap. June 2014. RMNCH TF-Evaluation Dropbox Folder.

¹⁵ Source: RMNCH Trust Fund Project Round Two Malawi. January 2017

identified and so scaled back to 12 districts in grant 2 to have the biggest possible impact, but recognized that the process had helped to maximize resources and limit duplication. It was noted that NORAD had undertaken some related activities on adolescent education and reproductive health, and USAID and DFID supported purchase of commodities.

Evaluation Question 2: Effectiveness

How effectively were RMNCH Trust Fund supported grants implemented at country level?

To what extent was Trust Fund global and regional programming support available and utilized to facilitate effective implementation?

Disbursement delays:

Malawi was one of the countries where funds were disbursed from the UNICEF central level to the country level, but there was a delay in recognizing that the funds had been disbursed. All implementing partners reported delays in funding either due to lengthy proposal negotiation processes, administrative requirements, contractual issues between international institutions, or the need to train accounting staff in reporting requirements. One issue that was repeatedly mentioned was a decision by the government that all training would need to be “full board” instead of participants receiving meal allowances. This required recalculation of training budgets because full board is more expensive, and reportedly fewer individuals were trained or were interested in being trained because of this.

Factors facilitating or impeding rapid implementation

Evaluation respondents were universally complimentary about the role of the SCT and the role of UNICEF in-country (see Table 9).

Table 9: Malawi: Factors Facilitating or Impeding Rapid Program Implementation

COUNTRY	FACILITATING	IMPEDING
Malawi	<ul style="list-style-type: none"> UNICEF was easily reachable, communicative about funding and refunding/retraining processes UNICEF flexible about working with organizations to harmonize financial reporting systems Flexible about prioritization of gaps and reprioritization, where to channel resources in terms of types of activity or district/facility Beneficial that procurement was not done locally for the UN system but through a centralized mechanism in Copenhagen. 	<ul style="list-style-type: none"> MOH Directorate schedules. Many activities funnelled down to RH Directorate and district level Challenge of absorptive capacity for increased number of activities Full board policy instituted by government during the project. Required renegotiation of funding and fewer trainees could participate High staff turnover at district level – requires persistent retraining Lancet article on concerns of safety of dexamethasone, despite later reassurances from MOH

Programming support:

The MOH and UN agencies in country received support from the SCT, local consultants or support from headquarter agencies. Respondents indicated that there were not very many in-country visits by the SCT, but their inputs were perceived to be available, utilizable and effective through regular teleconferences. We did not find evidence of involvement of TRTs in Malawi. Local partners, such as PACHI or Mai Khande, did not routinely interact with global support mechanisms, but rather dealt with the in-country UN agencies, particularly UNICEF and this was deemed sufficient and supportive.

Provider Capacity, Opportunity and Motivation to provide services:

In grant 1, the specific objectives were to strengthen the capacity to promote rational medicine use; strengthen the LMIS to support supply chain activities; improve mechanisms for ensuring quality RMNCH commodities; increase demand for RMNCH services in health facilities; and strengthen supply chain planning, coordination and collaboration of MOH and its partners and technical programs. There was more emphasis on updating and improve regulatory systems, protocols, standards, and guidelines in this grant, in addition to training.

Table 10: Malawi: Grant 1 Capacity Building

MALAWI: TYPE OF TRAINING ¹⁶	NO. OF INDIVIDUALS TRAINED/PLANNED
Orientation of health workers to updated Malawi Standard Treatment Guideline and Essential Medicines List (Medical Officers, Nursing Officers, Nurse/Midwife Technicians, Medical Assistants, Pharmacists)	520
Drug management, including LMIS reporting – Facility In-charges and Health Surveillance Assistants (HSAs) in all health districts	1753
Chlorhexidine, Mag. Sulphate (Target was 160)	616
Antenatal Corticosteroids	350
Long Acting and Reversible Contraceptives (LARC) (Target was 500)	380

After the training on chlorhexidine and magnesium sulphate, there were reports of low and incorrect use of magnesium sulphate. The RHD asked to increase the number of service providers trained to reinforce and standardize this treatment for pre-eclampsia. The number of health workers trained in LARCs was reduced after a request by the RHD to support supervision post-training to ensure that knowledge and skills gained were being utilized.

Other major undertakings of the grant contributed to improving the opportunity for providers to use their newly-acquired skills. The National Standard Treatment Guidelines and Essential Medicines List were revised, printed and distributed. LMIS forms, stock cards, standard operating procedures and requisition and issue vouchers were revised, updated and distributed. Dexamethasone and Chlorhexidine were distributed in 2015. The non-pneumatic antishock garment (NASG) was introduced and trainers trained in its use. A national EmONC assessment was undertaken, visiting 87 hospital and 278 health centres, and the results disseminated in July 2015. Steps were taken to strengthen supply chain planning, coordination and management and regular drug audits were instituted.¹⁷

For the second grant, the decision was made to focus on strengthening services in 12 districts with poor maternal and child health indicators. The five objectives included procurement of equipment and supplies; capacity building on RMNCH interventions; quality improvement for RMNCH services; community engagement on RMNCH; and strengthening RMNCH leadership and management. Many providers of different cadres, at different levels of the health system received support for capacity development, depending on implementing partners' expertise and strategy. See Table 11.

¹⁶ Source: RMNCH Trust Fund. 2014-2015 Final Report 2014-2015. December 2015

¹⁷ Ibid

Table 11: Malawi: People trained

MALAWI: TYPE OF TRAINING ¹⁸	NO. OF INDIVIDUALS TRAINED/PLANNED
Basic Emergency Obstetric and Neonatal Care	268/165
Community-based Maternal and Neonatal Care	1176/2200
Community Provision of Depo Provera	1700/1500
Female Surgical Sterilization	180/4000
WHO Post-natal Registers	2000
PNC Registers (DHMT members)	670/600
Build capacity of management and health care workers on CQI processes	143/200
Community Mobilization for Family Planning (HSAs and Supervisors)	1700/1500
Advocacy Workshops with FBO/NGO/Community Gatekeepers	837/600
Orientation on Family Planning – for family motivators	190/300
Orientation on Family Planning – for media personnel	90/200

The LSCs were included in policy, strategy, protocols, guidelines, job aids and checklists and the Essential Medicines List. Sixty ambulances were provided to support referrals of emergency cases to hospitals and 2000 bicycles were provided for the use of HSAs. Respondents noted that funding to support maintenance and running of the ambulances remains a challenge. Basic CBMNC equipment, equipment for newborn care corners, equipment for IUCDs and sterilization procedures, and FP commodities were provided. A baseline comprehensive quality of care assessment was conducted, along with periodic evaluation of RMNCH service quality of care. DHMTs in 12 districts received ongoing support for the introduction and maintenance of the District Health Performance Improvement Process.¹⁹

Respondents noted the challenges of high staff turnover affecting the ability to maintain quality services. They also noted challenges related to a policy regarding payments to trainees, requiring organizers to provide full board for trainees rather than providing an allowance for meals. This had resulted, they suggested, in fewer individuals being interested in training, and in fewer individuals being trained because of a need to rework budgets. Nonetheless, it was acknowledged that training motivates providers and, in Malawi, for the first time, we heard appreciation for TF support for mentoring.

“Midwives were afraid to perform some signal functions. Training provided the motivation and confidence to do this and save lives. Analyzing data and being able to talk with others about this was also a motivation.” Implementing partner Representative

“If you provide a conducive environment, people are motivated to do good work. Supervision and mentorship are important...We need to train more mentors and help these individuals who are working alone.” UN Agency Representative

User Capacity to Effectively Demand and Use RMNCH Services

In grant 1, one of the main activities included engaging Health Facility Advisory Committees (HFAC), Village Health Committees (VHCs) and other community leaders to empower them to support increased service utilization, particularly for delivery, FP and adolescent health. HFACs helped to monitor

¹⁸ RMNCH Project Summary 29092016. PowerPoint Presentation

¹⁹ Ibid

drug/supply flows to health centres on a monthly basis, enabling them to let communities know when stock-outs occur. Messages were prepared and transmitted through local radio stations and radio listening clubs were established in 5 targeted districts to promote access and use of RMNCH services. A pilot mobile health program, “ANC Connect,” was established on a toll-free hotline to provide clients with RMNCH advice, “tips and reminders” for pregnant women or new mothers, and a messaging system to remind pregnant women and their HSAs of ANC visits and in-facility birth planning. During a four-month pilot, 863 women were enrolled, 209 ANC visits were logged, 22 birth plans and 47 deliveries were recorded. The results of the pilot were shared with the Safe Motherhood Technical Working Group with recommendations for system improvements.²⁰

In grant 2, the focus was on enhancing FP utilization in the twelve target districts, early care seeking behaviour, and increasing blood availability in district hospitals in five selected districts. Community engagement for voluntary blood donations, succeed in adding 2067 individuals to the Voluntary Blood Donor Pool. A total of 13,336 pregnant women were also identified and referred for services through engagement of VHCs.²¹

Three local organizations, MHEN, Mai Khande and PACHI, focused attention on community mobilization, accountability, transparency and governance. Evaluation respondents informed us that partners organized one day orientations and services to increase community awareness of, and access to, long-acting and permanent method of contraception. It was noted that some areas are only served by Catholic facilities, limiting access to family planning services. MHEN has raised this issue with parliamentarians, but the issue has yet to be resolved. Similarly, it was noted that the young are often excluded from RH services and the 2016 DHS shows that adolescent pregnancy has increased. HSAs were trained in community mobilization to increase community awareness of RMNCH issues, and collaborated in the identification of problems in the 12 target districts with community groups and village health committees to find solutions. In addition to targeting women, these initiatives reportedly included working with local Chiefs, other leaders and with men. Service uptake and awareness of RMNCH issues reportedly increased, though the evaluation team was unable to secure data to document this. PACHI successfully mobilized communities to voluntarily give blood donations. This approach was successful and has continued beyond the life of the project.

The community focus was on the general population, and the needs of vulnerable populations or gender issues were not specifically addressed. A few of the organizations did address engaging men as partners, including inviting them to the facilities with their partners. On a field visit to Dedza, the evaluation team was informed that a large number of clients from Mozambique attend Malawian health facilities because of the porous border. Anecdotally, they appear to have worse health indices and are believed to contribute disproportionately to mortality and morbidity rates at facilities near the border. Dedza and surrounding areas are geographically challenging because of the topography. While ambulances have been provided in this area and should help to increase access to emergency care, it was reported that running costs for drivers, maintenance, and especially fuel, continue to plague effective use.

Evaluation Question 3: Efficiency

To what extent were the Trust Fund supported initiatives at country level implemented to achieve prioritized health goals and maximize resource utilization?

²⁰ Ibid

²¹ Source: RMNCH Trust Fund. *Round Two Malawi: Final Report*. January 2017

Coordination without duplication:

In Malawi, coordination improved over time, with monthly meetings led by the Directorate of Reproductive Health facilitating this process. In grant 1 the focus was on strengthening the supply chain for the 13 LSCs, and grant 2 was focused on improving alignment and consideration of new strategies at the national level. The MOH, UN and other partners came together to plan and prepare for implementation. The landscape synthesis process, resource mapping and gap analysis helped to identify priorities that were considered feasible within the timeframe and budget available.

In grant 2, 12 target districts with poor indicators were identified. Alignment coalesced around procurement and distribution of product, avoiding duplication of effort, implementation, and collaboration on specific initiatives. For example, for newborn units, UNICEF renovated facilities, SAVE and the MOH supported capacity development, Rice University provided ventilators, SSDI supported capacity building and QI. There were occasional disruptions due to overlapping priorities at the district level, but the DHMTs helped to resolve these by determining who would work in which areas. The MOH actively sought to avoid duplication through the selection of different districts for work by different partners. Partners worked within the government system, there were no parallel programs. CHMTs selected health centres where there was a gap. Partners shared messages so that IPs working in different districts could accomplish similar goals. For example, demand creation partners shared messages regarding the benefits and processes for blood donation, or coordination between Plan International and Mai Khande working on MNCH at the community level where again, the DHO facilitated them working in different areas.

Two respondents expressed concern that there was no joint monitoring of programs, although this was discussed; and that coordination did not go as far as it should have. There was no clear indication to one individual, despite the logframe, of how activities were linked to a foundation or framework. This same individual expressed frustration of what had been learned and where the program should be going. (UN and NGO representatives)

Sequencing of activities

Sequencing of activities went well. Few challenges were identified. The major challenge cited was that an article in the Lancet about the use of Dexamethasone halted expansion of its use until a review by the Pharmacy, Medicines and Poisons Board (PMPB). Once the review was completed, this was resolved. However, a 2014 article in the Huffington Post noted a significant stockout of the drug, estimating that a year's worth of supply (300,000 doses) would take many months to arrive.²²

Responsiveness to national and sub-national needs.

All district health teams were brought in separately by the MOH/RHD for gap analysis and workplanning in Grant 2, but it was unclear to respondents how much of those inputs were taken into consideration in alignment of partners at district level and in facilities. DHOs and zonal managers participated in planning and tailored broad goals to their district's needs. Clearly the intent was to engage the sub-national level. District level data helped to prioritize interventions and a data dashboard helped to determine issues to be address in each district.

Evaluation Question 4: Sustainability

To what extent is it likely that RMNCH results achieved with a contribution by the RMNCH Trust Fund will be sustained beyond the end of the Trust Fund through the availability of alternative funding sources (domestic or international) and continuous programming support?

²² Source: Barker, P.M. *Needless Crisis in Malawi for Babies Born Too Soon*. The Blog. Huffington Post. June 23, 2014.

Reach, Intensity, Duration to Sustain Services

Some skill sets and management systems have been put in place that will sustain interventions in the short or medium term in the 12 target districts. These include data systems and dashboards for monitoring progress at the district level, QI approaches, skills in family planning, CEmONC, BEmOC, newborn care, and some pre-service training elements. Partnerships and MOUs between CSOs the MOH for continued harmonization in their work at the district level will also continue (for example MHen and PACHI). LMIS monthly reports from districts and the supply chain at central hospitals have improved significantly. The PMPB did not have its own lab for quality control and was able to secure funds from the Global Fund to construct one, and pharmacovigilance has improved. Neonatal audits are now sent to the Safe Motherhood Coordinator, and while the data collection process can continue, there is still a need to help with analysis and developing action plans.

Many providers were trained of different cadres and facilities in the 12 target districts; service equipment and supplies were procured, although access to supplies will remain an issue; bicycles for HSAs and ambulances will remain, but resources for maintenance and running expenses for the ambulances remain an issue, despite being included in DHMT budget plans. (One individual estimated that districts receive approximately 40% of what they need for their whole budget and running costs for ambulances are low on the agenda. Alternative strategies, like working with communities to ensure funding availability, are critical to the sustainability of referral systems.) The introduction of the new WHO Quality of Care Network has the potential to motivate those trained in quality improvement.

One respondent noted that the TF agenda had been completed and some activities continued at the community level, but “You cannot see behavior change in one year.” There were continuing requests for support that were going unanswered (NGO Representative). One UN representative reported that it is imperative to continue in the 12 districts originally identified, and to begin to address the other districts if true change is to happen. An NGO representative felt that the “visibility created by the Trust Fund has been lost.” And again, respondents cited the short duration of the TF and the intention to serve as a bridging fund, rather than to put in place sustainable systems.

Documentation of Lessons Learned

As noted above, one respondent felt that lessons learned were unclear, and that this was important for future planning. It was suggested that documentation is a human resource issue, both in terms of availability and skills of staff, and not much documentation of lessons learned was done or planned. Activities were completed, but M&E and documentation suffered because of the shortage of time. For example, change in practice has not been documented. Two documentation pieces are anticipated for April 2017: the LSTM is preparing findings on its operations research study on quality improvement, and MSH is preparing a comparative summary of the implementation and results of the District Health Performance Improvement (DHPI) program. Respondents that reporting requirements for grants had been complied with, but challenges in processes and the solutions to them had not been gathered.

Scaling up with Alternative Resources

The funding and technical support provided were responsive to national and sub-national needs. However, respondents asked “When do we move beyond the 12 districts and the Trust Fund?”

“Nothing is completed. This is ongoing work. Achieving 100% of the target you set is simply accomplishing what you set out to do, but women and babies are still dying.”
UN Representative, Malawi

Some partners made use of other funding sources when TF disbursement was delayed. Others were already working in other districts and added to, or expanded the work they were doing to the TF supported districts. Otherwise, not much vertical or horizontal scale up was anticipated.

Respondents suggested that moving forward was not really an issue of “scaling up.” There is one national plan to which the TF has contributed resources and achievements.

Integration of Unfinished Business into New Strategies and Plans

The MOH and UN are discussing continuation of national plan activities through different mechanisms:

- Organized Network of Services for Everyone (ONSE), the recently awarded USAID program, will consider how to continue work on DHPI and other TF-supported activities.
- Mzimba, a local NGO, has promised to renovate a neonatal unit.
- Mai Khande applies a standardized approach to its work and is now working in 3 or 4 new districts with other funds to scale up the work done under the TF.
- Chemonics continues to support the MOH in LMIS with USAID support.

Malawi had no explicit exit strategy and was not included in the first wave of the GFF. They are, however, preparing proposal documents for a business case in the hopes that they will be included eventually.

Evaluation Question 5: Added Value

To what extent did the RMNCH Trust Fund and related processes contribute to an overall acceleration in progress toward achieving MDGs 4 & 5 in the programme countries. Was the Trust Fund support complementary and catalytic to other sources of investment in RMNCH?

Perceived Catalytic and Complementary Effects

Most respondents reported that the TF had been a significant catalyst in helping to redefine the importance of RMNCH by mobilizing resources, improving alignment, partnership and coordination, promoting engagement of implementers and donors, defining standards, and improving district health performance and alignment with national policies and plans. It complemented what had already been done and was planned. While much of the work undertaken was not new, it strengthened existing structures and skills and helped the country to address known challenges. It promoted a joint effort towards reduction of morbidity and mortality.

One NGO respondent, however, was not convinced about the catalytic effect, largely because of dissatisfaction with the MOH and the way it operates. This respondent perceived the system to be unprepared to deal effectively with the variations among districts due to differences in population, topography, geographical size. One size does not fit all and this had not been taken sufficiently into account.

Perceived Acceleration of Improved Access

It was perceived that utilization had increased, although noted that this could not solely be attributed to the TF-supported activities. People have more knowledge at the community level, more people are using LARCs, there is an increase in adolescents going to clinics for mother and child care, and the availability of ambulances for referrals increases the potential for access to emergency care. There are fewer stockouts, commodities are available at facilities, and the capacity of

“TF contribution was small in financial resources, but significant programmatically. The decision was made to invest resources where mortality and disease burden was high. This provided a ‘push’ in specific areas. It was a significant catalyst and I would expect it to bring more resources, but this is not yet realized.” UN Representative

“Documentation is needed to ensure effective mobilization and use of resources. The MOH is not able to make the business case for resources as is the case in the agriculture and education sectors.... Donors are not willing to make investments in healthcare due to accountability issues.” NGO Representative

health workers in rural areas has improved. RMNCH work has been revitalized, but continued investments are needed, and support at the highest levels are required.

While it is not possible to attribute improved outcomes to TF-supported outcomes, the recent DHS 2015-2016 survey of Malawi does report some encouraging and a few worrying trends (see Table 12).

Table 12: Malawi: Data from Demographic and Health Survey 2015-2016²³

INDICATOR	DHS 2010	DHS 2015-2016
TFR	5.7	4.4
Median birth interval	36.1 months	41 months
Teenage childbearing (15-19)	26%	29%
Children born too soon (interval less than 24 months)	15%	12%
Modern contraceptive use	42%	58%
Demand for FP	72%	78%
Under-five mortality (per 1000 live births)	112	63
Infant mortality rate (per 1000 live births)	66	42
Neonatal mortality (per 1000 live births)	31	27
ANC from skilled provider	95%	95%
Maternal mortality (per 100,000 live births)*	-	439
Pregnancy related mortality (for 7 years before each survey, per 100,000 live births)	675	497

**Previous DHS surveys measure pregnancy-related mortality and not the specific WHO definition of a maternal death: while pregnant, during deliver or in the 42 days after the delivery or within 42 days of termination of pregnancy. Prior estimates of maternal deaths refer to deaths within two months after a birth rather than 42 days after a birth. "Thus, current estimates of maternal mortality are not comparable to estimates from previous MDHS surveys in which only pregnancy-related mortality could be estimated. To assess the trends over time, pregnancy-related mortality was calculated for the 2015-2016 MDHS in the same way that it was calculated in previous MDHS surveys."*²⁴

Particularly important from this data is that Malawi is known to have achieved its MDG 4 target of reducing from 242 under-five births in 1990 to 81 by 2013, and by 2015-2016 it had reached 63. While MDG5 did not reach its target of reducing from 1100 to 280, it did achieve a 40% reduction, with some tapering off in the decline since 2005. Additional good news is that the neonatal mortality rate had been somewhat stagnant for many years, but dropped from 31 to 27, although there is still more work to be done. Respondents were concerned about the increase in adolescent childbearing and felt that there was a need to redouble efforts to address adolescent reproductive health needs.

Overleaf:

[Malawi Dashboard](#)

²³ National Statistical Office (NSO), Malawi and ICF. *Malawi Demographic and Health Survey 2015-2016*. Zomba, Malawi, and Rockville, Maryland, USA. February 2017

²⁴ Ibid. p 248.

MALAWI

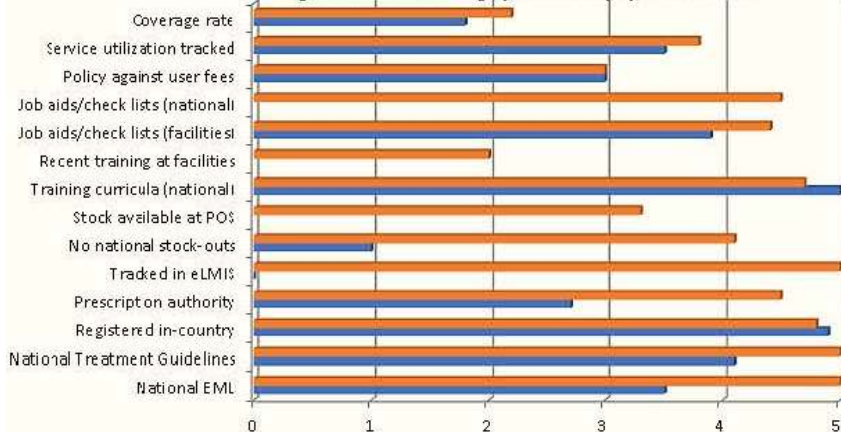
Country Context



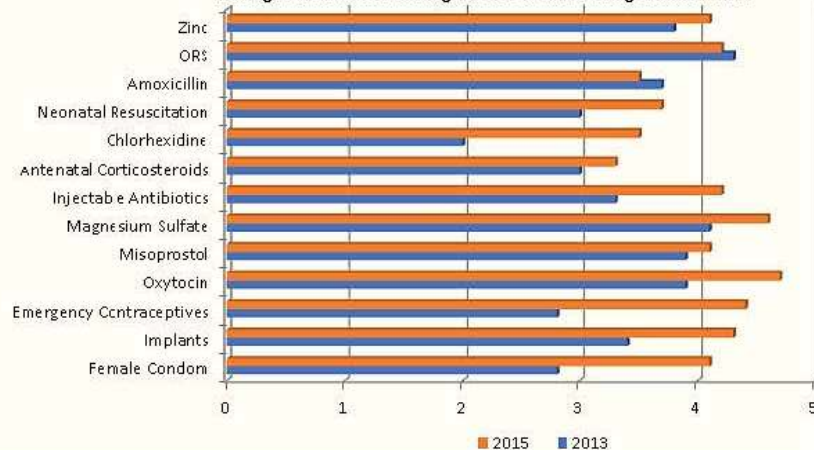
	2012	2015
Total population (000)	15,906	17,215
Total under-five population (000)	2,859	2,954
Total under-five deaths (000)	43	40
Under Five Mortality, per 1,000	71	64
Neonatal deaths (% of under-five deaths)	34	34
Neonatal mortality rate (per 1000 live births)	24	22
Infant mortality rate (per 1000 live births)	46	43
Total fertility rate (per woman)	5.5	5.0
Maternal Mortality Ratio, per 100,000 live births	510	634

Landscape Synthesis Reports

Average Performance Rating by Commodity-specific Indicator



Average Performance Rating for the 13 Life-saving Commodities



Objectives & Activities

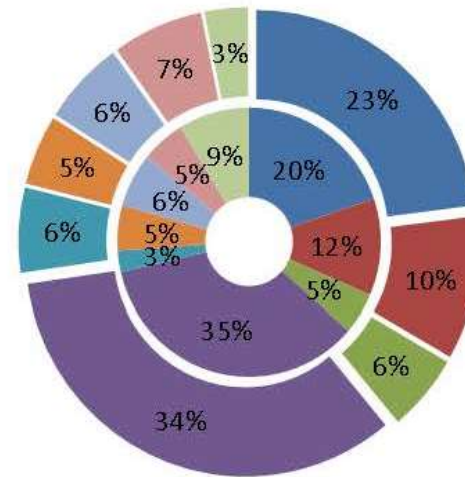
Round 1	Round 2
<ul style="list-style-type: none"> ✓ Strengthen capacity to provide rational medicine use ✓ Strengthen logistics management information system to support supply chain activities ✓ Improve mechanisms to ensure quality of RMNCH commodities ✓ Increase demand for RMNCH services in health facilities ✓ Strengthened supply-chain planning coordination and collaboration of MOH with its partners and technical programs ✓ Improved financial mechanisms for RMNCH services 	<ul style="list-style-type: none"> ✓ Ensure availability of essential equipment, including strengthening referral system in twelve districts ✓ Build the capacity of health workers to improve quality of RMNCH services in twelve target districts ✓ Strengthen quality improvement and institutionalize continuous quality improvement processes at health facilities in five districts ✓ Strengthen demand creation and social mobilization activities in the 12 districts ✓ Strengthen leadership capacity of District Health Management Teams in seven districts



Total Budget VS Total Expenditure

Outer Circle: Total Expenditure, Inner Circle: Total Budget

Total Budget: \$11,555,255 Total Expenditure: \$11,502,586



- Infrastructure and Other Equipment
- Advocacy/communication
- Coordination and management
- Human Resources for Health
- Medicines and Pharmaceutical Products
- Monitoring and Evaluation/Research
- Overheads/Indirect costs
- Policy and guidelines development and/or update
- Procurement and Supply Chain Management (PSM)

Channelling Agencies

UNICEF
UNFPA
WHO



Implementing Partners

MOH, CHAI, JSI, Malawi Health Equity Network, Mai Kande, MSH, PACHI, UNICEF, WHO, UNFPA

TANZANIA

Evaluation Question 1: Relevance

To what extent were the RMNCH Trust Fund global support and supported interventions at the country level clearly focused on addressing bottlenecks and gaps in RMNCH commodities, services and resources at the country level to accelerate achievement of MDGs 4 & 5?

Beginning in 2013, Tanzania received two grants from the RMNCH TF as follows:

Table 13: Tanzania: Grant

GRANT	BUDGET
Improving access to 12 LSCs (not Chlorhexidine)	\$4,000,000
Fast-track delivery of tangible and sustainable results in MDGs 4&5 by addressing priority areas in RMNCH in the Lake and Western Regions of the country	\$11,866,473

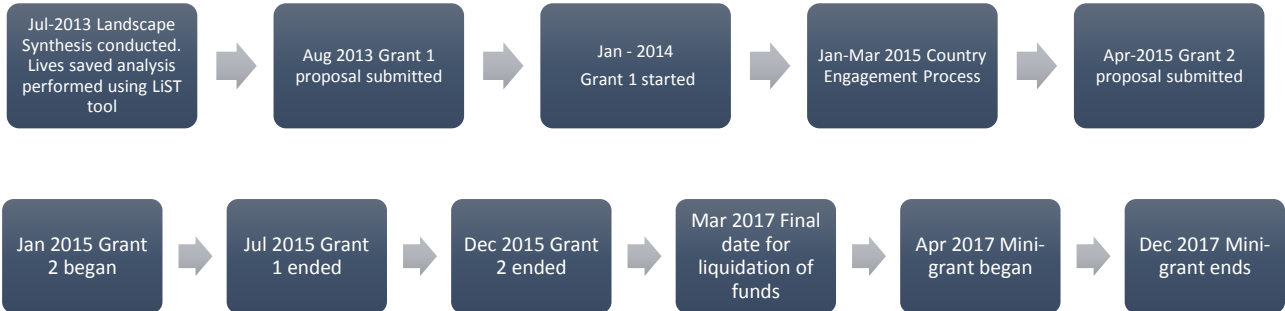
Zanzibar’s health system is semi-autonomous and it received separate grants in the amounts of \$701,000 and \$576,912.

The first grant to Tanzania Mainland focused specifically on addressing 12²⁵ of the 13 LSCs recommended by the UNCOLSC, emphasizing registration and regulatory issues, updating guidelines and standards, supporting a nationwide BEmONC assessment and rolling out systems to support improved supply chain management.

The second grant expanded to address activities that would result in improved results in MDGs 4&5 with a focus on two geographically and economically disadvantaged regions with poor health indicators: Lake and Western. Activities would include delivery of integrated RMNCH services, facility construction or upgrades, procurement of equipment, commodities and supplies, an improved referral system, and a strengthened MDSR.

In 2017, it was agreed that Tanzania could utilize remaining funds as a “mini grant” to help prepare for its involvement in the GFF.

Figure 4: Tanzania Timeline



²⁵ Chlorhexidine was not included because providers had recently completed training on alternative cord care.

Engagement of all stakeholders:

Respondents noted that processes for grant 1 were top-down and commodity driven. The TF had significant government leadership and ownership from the beginning in terms of planning and implementation. The immediate former President Kikwete was co-chair with the Canadian Prime Minister on the UN Commission on Information and Accountability for Women and Children's Health, and brought that political will to Tanzania. The Minister of Health was involved in the initial UNCOLSC Abuja and Dakar meetings and advocated for Tanzania to be one of the "pathfinder" countries. The Director of Preventive Services was a member of the Global Steering Committee and so could provide guidance on in-country strategy and planning. The Tanzania Food and Drug Administration (TFDA) was part of the initial planning to help set up templates that could be used by other countries. RHCH was the coordinating institution.

For grant 2, stakeholders included Ministry of Planning, Economy and Empowerment and the Ministry of Health and Social Welfare (MOHSW), and later on the Prime Minister's Office of Regional and Local Government (PORALG), the three UN agencies – UNFPA, UNICEF and WHO, NGOs and bilateral donors and their implementing partners (JSI, AMREF, others).

In both grants, UN bodies and implementing partners were engaged according to comparative advantages. For example, WHO focused attention on health systems strengthening (HSS), RMNCH Scorecards, provision of equipment and ambulances and quality of care; UNICEF focused on newborn and child health; UNFPA focused on reproductive health and FP. JSI was the focal point for supporting logistics and supply chain management in grant 1.

While the government led the planning and implementation, UNFPA was praised as the administrative and coordinating body. TAMISEMI was the coordinating body. The three agencies procured different items in accordance with their mandates and resources, in collaboration with the TFDA. The UN agencies had prior experience of collaborative work (joint project from 2007-2011, H4+, etc.) and had learned lessons from those experiences and provided support, but focused attention on ensuring that the government took the central leadership role. Evidence suggests that planning and implementation worked better for the second grant because partners had learned from the previous experience, and had a shared understanding of each partner's role and responsibilities.

It was generally agreed that local government should have been engaged at an earlier stage through PORALG and that some opportunities and synergies had been missed by not doing so.

Identification of bottlenecks and gaps:

For grant 1, as indicated in the time line, an analysis of lives saved if access to the LSCs were increased was conducted using the LiST tool and a landscape analysis was prepared. Of the 10 recommendations put forward by the UNCOLSC, following a review of the country situation, the government decided to focus on four: regulatory authorities and registration of some commodities; supply chain management and awareness; demand creation; and accountability. Zanzibar focused on equipment and supplies in this first grant.

For grant 2, in preparation for determining bottlenecks and gaps, the TF country team considered the "Roadmap for Reduction of Maternal and Neonatal Mortality," the "Sharpened One Plan 2014-2015" under the "Big Results Now" initiative (BRN), and the One Plan II which sets RMNCAH targets to be reached by 2020.²⁶ The country team conducted resource mapping to determine what partners were doing and where, to leverage resources and avoid duplication.

²⁶ Dutta, A. et al. Maternal, Newborn, and Child Health in Tanzania: Costs and Impacts of the One Plan II, Policy Brief. Futures Group. Washington D.C. September 2015

Respondents indicated that in both grants, issues and challenges were known and documented, but they needed to be prioritized according to the availability of limited resources and mapping of partner inputs. The Landscape Synthesis report was an important tool to understand how commodity availability had increased, but there was still a question about utilization.

UNFPA led the first national assessment for the TF through which it was identified that not only Lake and Western Zones were not the only zones with poor indices.

Funding Gap

From consultations that led to a costed Sharpened One Plan, April 2014, the overall RMNCH need was estimated at \$206,180,327. The available funding was reportedly \$12,007,004, which meant the funding gap was \$194,173,323.

Evaluation Question 2: Effectiveness

*How effectively were RMNCH Trust Fund supported grants implemented at country level?
To what extent was Trust Fund global and regional programming support available and utilized to facilitate effective implementation?*

Disbursement delays:

Respondents reported initial delays in disbursement of funds from global to local level, especially for grant 1. It took some time for government and implementing partners to learn and effectively respond to UNFPA’s administrative processes. Disbursement from national to regional and local level could take up to four weeks and require many signatures.

Factors Facilitating or impeding rapid program implementation

Evidence shows that the first grant required a no-cost extension because of slow implementation. For the second grant, outstanding balances could be reprogrammed into min-grants for countries entering negotiations with the GFF – Tanzania was one of those countries. We had asked respondents to consider what factors facilitated or impeded rapid program implementation, and Table 14 summarizes their responses.

Table 14: Tanzania: Factors facilitating or Impeding rapid program implementation

COUNTRY	FACILITATING	IMPEDING
Tanzania	<ul style="list-style-type: none"> Political will Existence of national policy and strategic plans prioritized and tailored to limited resources UN agency partnerships and coordination strong at the country level Less silo programming and more integration into the health system Engagement of multiple partners to increase absorptive capacity and speed of response Solid UNFPA leadership UN agencies’ capacity for 	<ul style="list-style-type: none"> Duration of Trust Fund, geographic focus and resources – “a drop in the ocean” even for target regions Local government (PORALG) not meaningfully engaged early enough and adequately Short implementation grants not well suited to government implementation Employment frozen for new doctors and nurses for two years; deployment and attribution is problematic Delayed disbursement of funds in 2014 Cumbersome contract mechanisms Change of government

COUNTRY	FACILITATING	IMPEDING
	<ul style="list-style-type: none"> procurement, although considerable lead time for some items • Good support from SCT, including in-country visits and regular communications • TFDA received TF support for pre-registration and post-marketing surveillance of product 	

Programming Support

Respondents acknowledged SCT support during planning, proposal writing, teleconferences and visits. The SCT was perceived to be accessible, responsive and flexible in planning, prioritization and reprogramming based on local needs. They also provided consultants as needed. One example of flexibility cited was that the country team overspent on facilities. They requested permission to move other moneys around to compensate and this was granted. Consultation between the SCT, UNFPA and the MOH was fast and effective. UN agencies received support from their own teams. There is no indication of direct technical support from the TRTs.

Provider Capacity, Opportunity and Motivation to provide services

Stakeholders perceived that supported interventions addressed these three dimensions of sustainable capacity improvement. Addressing human resources for health was the second largest expenditure for the mainland and third largest for Zanzibar. Providers gained skills in LSCs, EmONC, blood donation and management, data management and analysis, LMIS, and quality improvement. The country logframe shows that the focus on capacity development was in training new CHWs for a 9 month period and providing integrated MNCH training for an additional three weeks. Providers were trained in Kangaroo Mother Care in four districts, in newborn resuscitation in one region, and in essential newborn care in three regions.

Table 15 provides a summary of training conducted under both TF grants.

Table 15: Tanzania: Summary of Training

TANZANIA: TYPE OF TRAINING	NO. OF INDIVIDUALS TRAINED/PLANNED
GRANT 1²⁷	
BEmOC and Life-Saving Skills (including NASG)	156
Orientation on MNCH services for CHWs	245
LMIS TOT	32
Commodity report and request forms	98
GRANT 2²⁸	
Youth friendly services	40
HWs/CMAs – nine month training	150
CHWs 3 week RMNCAH hands-on training	262

²⁷ Source: UNFPA. UNCOLSC Narrative Progress Report for the United Republic of Tanzania. Sept 2015.

²⁸ Source: United Republic of Tanzania. RMNCH Trust Fund Grant Closure Narrative Progress Draft Report. April 2017

TANZANIA: TYPE OF TRAINING	NO. OF INDIVIDUALS TRAINED/PLANNED
GRANT 1 ²⁷	
Tutors oriented on the new CHW curriculum	47
BEmONC	50
CEmONC Mentoring	50
TOT for ANC guidelines and training manuals adapted for Zanzibar	10
TOT for PNC guidelines and training manuals adapted for Zanzibar	40
Essential Newborn Care	1075
Kangaroo Mother Care (KMC)	102
RMNCH/HMIS/DHIS2 data quality auditing training	82

Providers now had better access to newly-registered LSCs. There had been some scepticism about generic drugs, but providers were reassured when manufacturers passed WHO’s Good Manufacturing Practice standards and pre-qualifications. Commodities such as female condoms were no longer regarded as only for use by commercial sex workers, and some of the cultural/religious resistance to misoprostol was ameliorated. This led to changes in prescribing habits of providers. However, condoms in general still needed major advocacy in Zanzibar and chlorhexidine was not yet registered.

The largest expenditure in Tanzania was on infrastructure and other equipment. When added to health products and health equipment, as well as medicines and pharmaceutical products and procurement and supply chain management, more than half the expenditures were to enhance the service environment to improve the quality of services that could be provided. The TF enabled the country team to refurbish eight CEmONC facilities, a dry store for vaccines and two blood banks. A total of sixty-seven ambulances were procured, sufficient for one for every district in the TF geographic focus area under grant 2. Fortunately, PORALG has committed to running costs for the ambulances so they can and will be in use. This is not the case in many other places. In addition, funds were spent on strengthening LMIS and HMIS systems. Anecdotally, the evaluation team was told that institutional delivery had increased four-fold in some facilities, and contraceptive prevalence has improved. There has also been some improvement in provider motivation from training, supervision and mentoring, as well as the improved infrastructure and supplies.

Nonetheless, evidence suggests that Tanzania continues to experience challenges to provider capacity, opportunity and motivation to provide quality services. There has been a government freeze on new clinical staff for the past year under the new government, and newly graduated doctors, nurses and Assistant Medical Officers (AMOs) have not been recruited. There continues to be an acute shortage of anesthetists, particularly felt in CEmONC facilities. Lack of staff housing, water and electric power are demotivating for providers and perhaps could have been resolved or alleviated by consultation with PORALG or foundations that would consider such support.

User Capacity to Effectively Demand and Use RMNCH Services:

As was the case in other countries, the demand side received less attention than the supply side. The perspective of respondents was that the first grant had been very top down, while the second grant had improved the involvement of local stakeholders significantly. AMREF conducted community outreach and demand generation activities, although it was felt that this was not well synchronized with the supply side, with facilities not yet fully functional at the time. While most community outreach focused on the general population, AMREF did specifically organize CHW visits for demand creation to prevent teenage pregnancy, to serve for the hearing impaired or physically challenged, and for economically and geographically disadvantaged populations. AMREF also supported 12 youth friendly centers (some

supported by the Trust Fund and others with other resources). PSI assisted with expanding marketing of the female condom to the general public, and similarly for emergency contraception and dispersible amoxicillin. There was also some marketing to attract new users to facilities: well-dressed staff and providers, broadcasts about the availability of ambulances, etc.

Evaluation Question 3: Efficiency

To what extent were the Trust Fund supported initiatives at country level implemented to achieve prioritized health goals and maximize resource utilization?

Coordination without Duplication:

Evidence shows that grant 1 began with a six-month delay, mostly due to cumbersome contracting processes. At the global level, many committees focused on the LSCs caused confusion and miscommunications at the national level. This was eventually streamlined.

The SCT began to communicate directly with all partners at the national level, rather than only to the UN at the national level. Respondents reported good coordination amongst a large contingent of partners in planning, mapping of resources, and comparative advantages to address MDGs, resulting in hardly any duplication of effort. Divided responsibilities meant that interventions could be implemented faster and no one partner was expected to do too much within the given timeframe. In grant 2, the contracting delays had been overcome, but there were still some delays in procurement of equipment, ambulances, often with more than six-months' lead time required. Local governments were engaged through PORALG in grant 2. Respondents felt that earlier engagement may have secured local ownership faster. For example, PORALG has responsibilities for ensuring water and power and can build facilities faster, unless there are delays in disbursements from the sub-treasury.

Duplication was avoided by coordination, joint planning and mapping of resources and discussion of comparative advantages to address the MDGs, knowing which partner had responsibility for activities, where and with what synergies. The partnership worked well with divided responsibilities leading to faster implementation and no one partner was expected to do too much.

Sequencing of Activities:

Most inputs to support improvement in service readiness and demand creation were perceived to be well sequenced. However, there was some less than optimal sequencing with regard to construction and upgrading of facilities, availability of staff housing, electric power, and water. Only one of the eight CEmONC facilities was fully functional at the time of the evaluation due to late delivery of equipment, training and especially the availability of anesthetists.

Responsiveness to National and Sub-national Needs:

Respondents were unanimous that funding and technical support had been flexible and responsive, especially once financial systems were in place. They were particularly appreciative that TF funds could be used as a bridge to secure GFF funds and TF activities were foundational to being able to do so.

Evaluation Question 4: Sustainability

To what extent is it likely that RMNCH results achieved with a contribution by the RMNCH Trust Fund will be sustained beyond the end of the Trust Fund through the availability of alternative funding sources (domestic or international) and continuous programming support?

Reach, Intensity and Duration to Sustain Services:

Respondents noted that partnerships between government, UN agencies and CSOs can be continued. The reach of the TF activities was 2 zones and 8 regions. Some programmatic achievements are sustainable in the short-term, such as training in the LSCs, EmONC, the availability of standards, commodity registration, and incorporation of the LSCs into EML. Investments in physical infrastructure included operating theaters, maternity blocks, blood satellite units and dry stores, and ambulances for referrals, and these will all be available assuming operational budgets are made available. Challenges to sustainability identified include that duration was short – effectively 15-18 months for grant 2; there are limited flexible alternative financial resources in-country; and a recruitment freeze of clinical staff and poor deployment of staff. The Tanzanian FDA registers commodities in-country and Medical Stores procures. However, there has been no funding available over the last three years for procurement locally, so manufacturers are discouraged to participate.

Documentation of Lessons Learned:

While the country team complied with the requirements for reporting, there was limited formal or systematic documentation and less dissemination of lessons learned. Respondents attributed this to the short duration of the project. There are reportedly plans to conduct additional documentation and dissemination, though none was specifically identified. It was suggested that some of the money left over from the Trust Fund (to be used for the GFF investment case) could be used to support and assessment and/or research on where things stand with newborn care.

Scaling up with Alternative Resources:

Some TF-supported interventions will be scaled up with alternative resources and programming support. For example, AMREF has upgraded facilities, trained providers, conducted community outreach and demand generation with TF and non-TF resources. Similarly, JSI was able to use other funding to support some of the logistics and supply chain management interventions and will continue to do so.

Integration of Unfinished Business into New Strategies and Plans:

Tanzania is a GFF country and sees the GFF as the direct exit strategy that will build on the TF supported interventions. The TF strengthened government systems and built on the government's stated priorities, and this will continue with both domestic and external support. Unfinished business is being incorporated into other internal and external budgets. Tanzania respondents noted that the US Administration's reinstatement of the Mexico City Rule may affect funding through USAID. JSI has been engaged by FP2020 in Tanzania to consider supply chain sustainability, capacity building and demand creation.

Evaluation Question 5: Added Value

To what extent did the RMNCH Trust Fund and related processes contribute to an overall acceleration in progress toward achieving MDGs 4 & 5 in the programme countries. Was the Trust Fund support complementary and catalytic to other sources of investment in RMNCH?

Perceived Catalytic and Complementary Effects:

Respondents viewed the TF as catalytic, leading to leveraged funding (GFF) and may have accelerated some aspects of MDGs 4&5. It was catalytic in mobilizing resources to a priority area in the national health plan. Resources contributed to upgrading facilities in target zones to meet standards that would enable them to “unlock” RBF resources. It contributed to improved access to, and use of, LSCs and

“Functional facilities provide a footprint for GFF or other funding, especially those requiring contingent delivery.”
MOHSW representative

RMNCH services. Under the GFF, Tanzania plans to implement RBF in the Lake Zone and two regions, based on an investment case partly developed with TF resources, including the EmONC assessment. It complemented other funding, for example WHO mobilizing additional resources from the One Fund and used non-TF WHO resources for maternal death reviews. WASH supported reservoir tanks and laid water pipes for TF supported facilities in Lake Victoria area.

Respondents noted that additional support had been leveraged from UN agencies during the period of the TF:

- UNICEF provided Amoxicillin, and supported training in use of commodities with non TF resources
- WHO supported similar TF activities through the One UN Fund in zones other than Lake or Western
- WHO supported the MDSR review of guidelines and training nationally, and not just in Lake Zone
- WASH supported reservoir tanks and laid water pipes from Lake Victoria for TF supported facilities

Perceived Acceleration of Improved Access

Most stakeholders perceived Trust Fund supported activities to have made some contribution to improved access and use. Anecdotally, as noted previously, in one community there had been a four-fold increase in facility deliveries and increased contraceptive prevalence. The TF had raised awareness and brought renewed focus to RMNCH at all levels. It had encouraged collaboration and coordination, the engagement of the private sector, built capacity, supported infrastructure and referral systems. The “counterfactual” is that this would not have been achieved without the TF support.

Data on Utilization

The duration of the RMNCH TF was too short to demonstrate any significant differences in utilization, nor was data specifically collected for that purpose. We know from Countdown to 2015 that Tanzania fell short of achieving its targets for MDGs 4 and 5 (49 and 230 respectively).

A 2015-2016 DHS was published in December 2016 and we may assume that some of the work done by the TF has contributed something to these results. Most indicators are continuing in the right direction, although much more remains to be done: TFR, the under-five mortality rate, infant mortality rate, and neonatal mortality rate are decreasing. Median birth intervals, modern contraceptive use, demand for FP, ANC from a skilled provider are all increasing. Respondents were concerned about the increase in teenage childbearing and the significant increase in maternal mortality, only slightly lower than ten years before. See Table 16 for data from the 2015-2016 Tanzania Demographic and Health Survey.

Table 16: Data from Tanzania Demographic and Health Survey 2015-2016²⁹

INDICATOR	DHS 2004-05	DHS 2010	DHS 2015-2016
TFR	5.7	5.4	5.2
Median birth interval	33 months	33.9	35 months
Teenage childbearing (15-19)	26%	23%	27%
Modern contraceptive use	20%	27%	32%
Demand for FP	51%	57%	61%

²⁹ MOHCDGEC Tanzania Mainland, MOH Zanzibar, NBS, OCGS and ICF. *Tanzania Demographic and Health Survey and Malaria Indicator Survey 2015-2016*. Dar es Salaam, Tanzania, and Rockville, Maryland, USA. December 2016

Under-five mortality (per 1000 live births)	112	81	67
Infant mortality rate (per 1000 live births)	66	51	43
Neonatal mortality (per 1000 live births)	31	26	25
ANC from skilled provider	95%	96%	98%
Maternal mortality (per 100,000 live births)	578	454	556

Overleaf:

[Tanzania Dashboard](#)

TANZANIA

Country Context



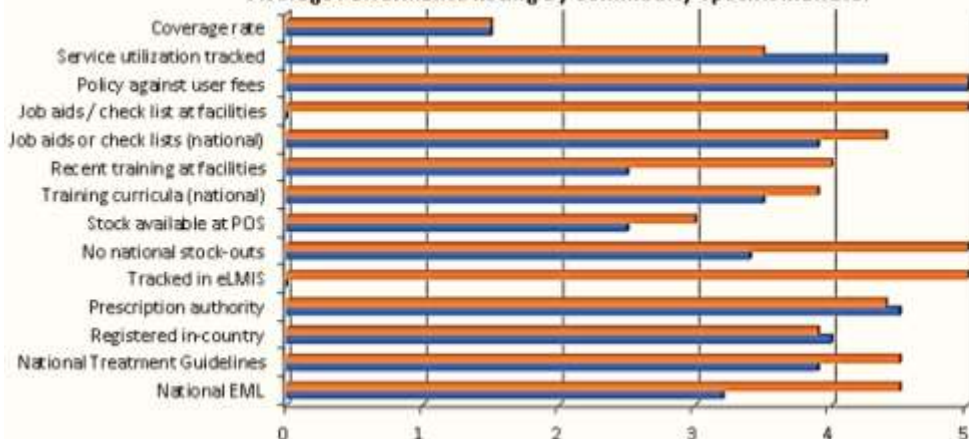
	2012	2015
Total population (000)	47,783	53,470
Total under-five population (000)	8,487	9,398
Total under-five deaths (000)	98	98
Under Five Mortality, per 1,000	54	49
Neonatal deaths (% of under-five deaths)	40	39
Neonatal mortality rate (per 1000 live births)	21	19
Infant mortality rate (per 1000 live births)	38	35
Total fertility rate (per woman)	5.3	5.1
Maternal Mortality Ratio, per 100,000 live births	410	398

Objectives & Activities

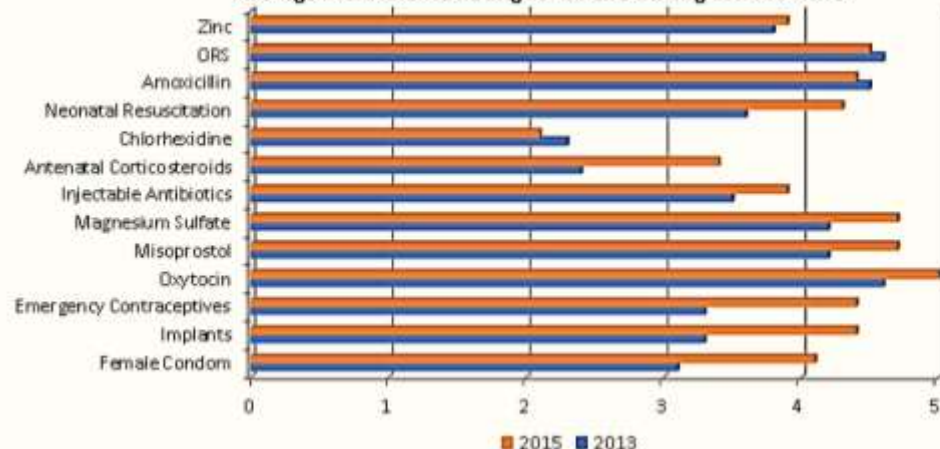
Round 1	Round 2
<ul style="list-style-type: none"> ✓ Registration of 12 LSCs ✓ Update of guidelines and standards ✓ Support nationwide BeMONC facility assessment ✓ Roll out eLMIS and ILS gateway systems to support supply chain management 	<ul style="list-style-type: none"> ✓ Strengthen health system to provide quality EmONC Services ✓ Strengthen capacity of health care providers to provide quality RMNCAH services ✓ Strengthen capacity of HMIS to capture information on MNCH indicators, including family planning and nutrition ✓ Ensure the availability of essential equipment and commodities for RMNCH ✓ Strengthen coordination and accountability

Landscape Synthesis Reports

Average Performance Rating by Commodity-specific Indicator



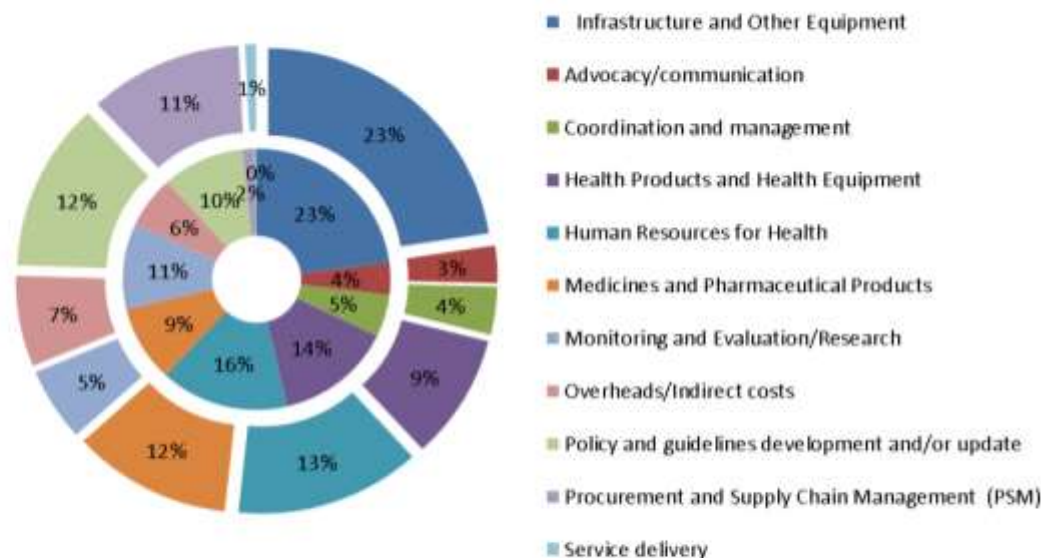
Average Performance Rating for 13 Life-Saving Commodities



Total Budget VS Total Expenditure

Outer Circle: Total Expenditure, Inner Circle: Total Budget

Total Budget: \$14,244,590 Total Expenditure: \$13,525,117



Channelling Agencies

UNICEF
UNFPA
WHO



Implementing Partners

MOH, TFDA, PMORALG
UNICEF, UNFPA, WHO,
JSI, AMREF-TANZANIA

UGANDA

Evaluation Question 1: Relevance

To what extent were the RMNCH Trust Fund global support and supported interventions at the country level clearly focused on addressing bottlenecks and gaps in RMNCH commodities, services and resources at the country level to accelerate achievement of MDGs 4 & 5?

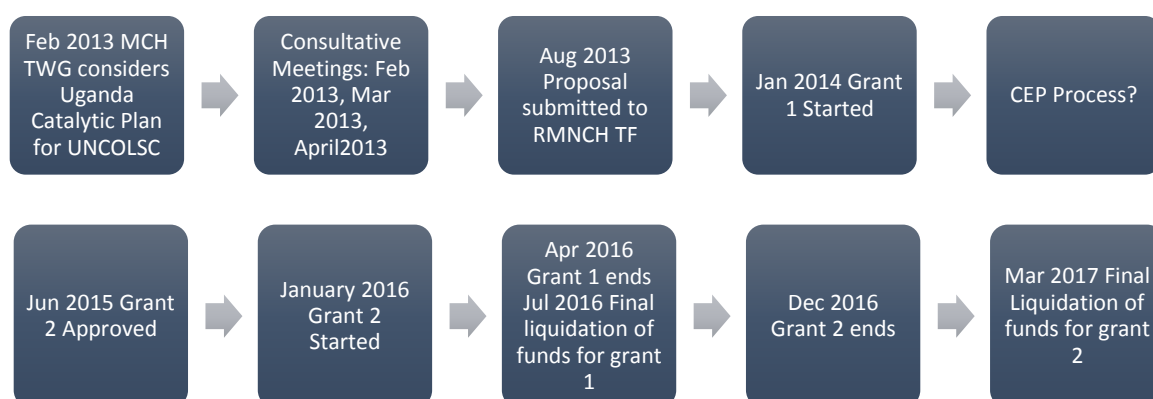
Beginning in August 2013, Uganda received two grants from the RMNCH TF as follows:

Table 17: Uganda: RMNCH Trust Fund Grants

GRANT	REQUESTED AMOUNT
UNCOLSC: Uganda Implementation Plan 2013	\$3,877,359
RMNCH Concept Note for Uganda	\$7,000,000

The objectives of these grants are listed on the dashboard. Uganda was one of the eight 'pathfinder' countries addressing the implementation bottlenecks for increasing access to the 13LSCs.

Figure 5: Uganda Timeline



Engagement of All Stakeholders

For grant 1, the Ministry of Health, under the direction of the Assistant Commissioner for Child Health, identified partners to be involved in implementation based on needs identified and perceived expertise; consortia or clusters were formed by partners with similar expertise forming partnerships within their districts. A series of consultative meetings was organized including the Mother and Child Health Technical Working Group (MCH TWG), the National Medical Stores (NMS), the National Drug Authority (NDA), the Pharmacy Division and the Medicines Procurement Technical Working Group (MPM TWG), National Newborn Steering Committee (NBSC), Integrated Community Case Management (ICCM) Committee, Diarrhoea and Pneumonia Prevention and Promotion and Treatment (DPCC) Committee, and the Family Planning/Reproductive Health Commodity Security Working Group.

The planned implementing partners for Grant 1 included the three UN agencies, CHAI, PATH, University Research Corporation (URC), Uganda Family Planning Consortium (UFPC), the Reproductive Health Uganda (RHU), the Communication for Development Foundation for Uganda (CDFU), Healthy Child Uganda (HCU), World Vision, Marie Stopes Uganda (MSU), Shines Children's Foundation, AMREF, Helika Ltd. Limited understanding of implementing partners' roles and responsibilities under Grant 1 and

challenges with early phase coordination contributed to delayed start-up. At this critical point, MOH Director General of Health Services, was appointed RMNCH Focal Point.

The focus of grant two was to increase coverage of high quality, high impact RMNCH interventions to accelerate reduction of MNCH mortality in Uganda. Interventions were selected by the MOH through a country engagement process, a “think tank” of stakeholders from the MOH Commissioners, selected District Health Officers, development partners, including H4+, USAID, RHU, Save the Children, representatives from academia. For grant two, implementing partners included the three UN agencies, MOH, local governments, Association of Obstetricians and Gynaecologists of Uganda (AOGU), the Population Secretariat, MSU, the National Blood Bank, Save the Children International, and JHPIEGO.

Identification of Bottlenecks and Gaps:

For grant 1, based on a WHO guidance note on priority MNCH medicines, Uganda had already prioritized 30 essential medicines and the 13 commodities were part of this list. This initial plan, based on a gap analysis, focused on UNCOLSC recommendations 6, 9 and 10: supply and awareness, performance and accountability, and product innovation.³⁰ The grant proposal was premised on three criteria: (1) global burden of disease, and evidence of high impact and efficiency to reduce morbidity and mortality; (2) commodities with no funds from existing mechanisms such as the Global Fund or GAVI; and (3) untapped potential and opportunity for innovation and rapid scale-up in product development and market shaping. This translated into three overarching objectives: to improve markets (considering the UNCOLSC recommendations; to improve national delivery and use, and increase performance and accountability; and to improve integration of private sector and consumer needs.³¹

The second grant was based on a CEP analysis of key documents including the Uganda Sharpened Plan, the National Child and Newborn Survival Strategy and the Uganda Road Map to Accelerate the Reduction of Maternal Neonatal and Child Morbidity and Mortality in Uganda. Through this analysis, key bottlenecks were identified in the areas of human resources for RMNCH, availability of commodities, infrastructure needs, low demand and access to services, and leadership and governance.³²

Funding Gap:

A resource mapping process was undertaken describing sources and period of funding, areas of funding and amounts. In the process leading to grant 1, there were several programs for which no financial data was immediately available from implementing partners or donors. The process led to an incomplete estimate of resources available, and did not identify a funding gap.

For grant 2 the country team undertook a resource mapping exercise using the estimated cost of interventions from the 2013 RMNCH Sharpened Plan. Again, some partners were not able to complete the tool. A review of the resource mapping tool identified that most programs supported by donors targeted the Northern and Karamoja regions which have the highest burden of maternal and newborn health.³³ The preliminary gap identified for one year was \$17 million (see Table 18)

³⁰ Source: Ministry of Health, The Republic of Uganda. *UNCOLSC Uganda Implementation Plan 2013*. 16 August, 2013

³¹ Source: Ministry of Health, The Republic of Uganda. *Uganda’s Catalytic Action Plan to Increase Access to Lifesaving Commodities*. Progress Report 2014-2015. Undated.

³² Source: Ministry of Health, The Republic of Uganda. *RMNCH Concept Note for Uganda*. Undated. (RMNCH TF Evaluation dropbox Uganda Grant 2_Narrative Proposal.pdf)

³³ Ibid

Table 18 Uganda: Estimated Funding Gap for 2015 (Grant 2)³⁴

INTERVENTION AREA	EXPECTED COST \$000	COMMITTED FUNDS 2015-2016 \$000	GAP 2015+2016 \$000	ANNUAL GAP ESTIMATE \$000
Maternal & Newborn Health	50	29	21	10.5
Child Health	215	204	11	6.5
Total	265	233	32	17

Evaluation Question 2: Effectiveness

How effectively were RMNCH Trust Fund supported grants implemented at country level?

To what extent was Trust Fund global and regional programming support available and utilized to facilitate effective implementation?

Disbursement delays:

Evidence suggests that the main challenge with disbursements was through the MOH. This resulted in delays in the sequence of activities or in some activities not being completed. Respondents did not report challenges with disbursement delays from UN agencies and some implementing partners stepped in to expedite procurements through their own organizations' mechanisms. For example, World Vision (coordinating partner), facilitated the purchase of a server with the permission of the MOH.

Factors Facilitating or impeding rapid program implementation

Strong authoritative leadership from the MOH and a strong partnership with UNFPA were important factors that facilitated rapid program implementation. Respondents reported that coordination meetings with all implementing partners focused attention on avoiding duplication, making it feasible to adjust plans and reprogram activities and funds as needed. The Country Team reported effective communications with the TF staff, both locally and the SCT for technical issues and for monitoring. The interest and expertise of the development partners was also credited with facilitating rapid program implementation.

At the beginning of grant 1, slow start-up procedures delayed activities for approximately six months. This was due to protracted procurement processes, time consumed in formation of consortia, multiple layers of administration, limited communications, and initial confusion about implementing partners' roles and responsibilities resulting in less time for implementation and increased pressure to deliver within a further abbreviated timeframe. The large number of partners in grant 1 was also seen as a factor that contributed to delayed implementation. These challenges were resolved when a focal point was appointed. Grant 2 had significantly fewer implementing partners involved.

Programming Support:

In grant 1, respondents reported receiving support from TRT mainly in support of messaging for commodities, but in grant 2 no TRT support was reported. Most respondents stated that technical and programming support was provided by SCT, channelling agencies, and local implementing partners. For example, WHO provided support for building and strengthening capacity at MOH in the MPDSR process.

Provider Capacity, Opportunity and Motivation to Provide Services

In grant 1, 396 health workers from 90 districts were trained to provide and use life-saving commodities. In addition, 838 health workers in five districts were trained in the use of the Uganda version of the IMCI

³⁴ Ibid

computerized adaptation training tool (iCATT). The focus of this grant was to strengthen the systems and environment for the safe provision of the LSCs. All 13 LSCs are now in the EML and a forecast for the period 2015-2020 has been prepared and there is annual tracking of the state of commodity manufacture, import and use through the landscape synthesis. The National Drug Regulatory Authority has strengthened its capacity to do post-shipment testing of commodities. KPI began marketing locally manufactured chlorhexidine in 2015, increasing availability³⁵. A new eLMIS system is ready for rollout. In maternal health, a QI roadmap and tools for maternal and neonatal health care have been developed and implemented; an eHealth Record system and RMNCH balanced scorecard have been developed and are ready to be rolled out. An e-health passport to track pregnant and postpartum women, confirm facility births, and verify health transactions nationally has been successfully piloted.

Based on the country's Sharpened Plan for RMNCAH, objectives in grant 2 emphasized strengthening high impact services for maternal health, newborn health, under-fives, and family planning, along with strengthened leadership and governance in target districts in the Karamoja, Western and Busoga Regions. In all a total of 30 high-burden districts were identified. The plan was to hire 90 midwives to support underserved facilities in these districts, although 76 were hired. More than 300 health workers were trained in delivery of LSCs; 300+ workers were trained in newborn resuscitation; and a total of 1,784 health workers were trained in integrated management of childhood illnesses-computerized adaptation training tool (iCATT). District Health Officers received training in leadership and governance for RMNCH. Selected facilities received support for water and solar lighting for labor and delivery and operating theatres and EmONC equipment was distributed to 60 under-resources facilities in three regions.

A voucher program has provided a mechanism for facilities to generate revenue for use on infrastructure and incentivizing health workers. Training and mentoring support are considered motivation. Performance based financing criteria for quality motivated providers to incorporate life-saving skills into their work.

User Capacity to Effectively Demand and Use RMNCH Services:

Maternal health vouchers were introduced to help some of the "poorest of the poor" women access ANC, labour and delivery and FP services. Vouchers made it possible for women to access hospitals rather than health centres for emergency care, though there were challenges for staff as a consequence of this increased access. The use of vouchers did result in increased uptake of services from 70-80 births per month prior to their introduction, to 130-150 per month after; and from 40 c-sections before introduction to 70-80 c-sections per month after introduction (Buluba hospital, Mayuge). Some challenges identified with this process that still need to be resolved include: some women were unable to pay for transportation to be able to use the facility vouchers; some women had inaccurate perceptions of what was covered by the vouchers; and staff voiced the concern that women with vouchers felt that they would be entitled to be served first, creating challenges with other women. Parliamentarians were engaged to champion RMNCH and adolescent health at the central level and within their communities. District health officers, political leaders, council chairpersons and members of security institutions were oriented on leadership and governance for RMNCH.

Evaluation Question 3: Efficiency

To what extent were the Trust Fund supported initiatives at country level implemented to achieve prioritized health goals and maximize resource utilization?

³⁵ Source: Uganda Ministry of Health, Uganda End of RMNCH Fund Phase II Grant Report, April 2017, page 11.

Coordination without Duplication:

In Uganda, UNFPA led periodic coordination meetings to ensure implementation of area-specific workplans, to coordinate activities to avoid duplication, and to ensure to the degree possible, completion within limited timeframes. The bottleneck analysis and Sharpened Plan created a platform for guiding the next five years. The RMNCH core team met quarterly to monitor activities, funding and spending, to problem solve and adjust workplans. Selected DHOs from target districts were included in the prioritization processes for grant 2. However, the ADHOs and facility staffs interviewed did not necessarily know the source of funds for activities implemented in their districts or with their facilities.

Sequencing of Activities:

Delays were mainly experienced in research activities. This occurred in proposal development and in securing ethical approval. Protracted procurement activities were also the case of some delays. This resulted in failure to implement some activities, for example, a proposed study to explore the feasibility and effectiveness of outpatient based neonatal sepsis management. Because of these delays four activities were dropped: implementing a comprehensive FP SBCC activity in target districts; facilitation of quarterly RMNCH review meetings; and pilot use of telemedicine provision of care to women and newborns with complications.

Responsiveness to National and Sub-National Needs:

The TF had made possible: pre-term birth surveillance (both the development of the program and training for a pilot); conducting adolescent health risk behavior studies to inform future programming; strengthening iCCM integration with TB services which could then be incorporated into a Global Fund concept note. The TF through the SCT was perceived as very responsive with regular phone calls, country visits, technical and programmatic guidance offered throughout the grant period.

Evaluation Question 4: Sustainability

To what extent is it likely that RMNCH results achieved with a contribution by the RMNCH Trust Fund will be sustained beyond the end of the Trust Fund through the availability of alternative funding sources (domestic or international) and continuous programming support?

Reach, Intensity and Duration to Sustain Services

As in other countries, in grant 1, the investment in regulatory systems, updating of EML, protocols and guidelines, and communications tools provided a solid base for increased availability of the LSCs which can be sustained. Political support for LSCs was mobilized through parliamentarians who are now empowered to inform their communities and to legislate on RMNCH issues. Members of Parliament have been trained in budget advocacy for LSC. Because of the TF advocacy and increased awareness of RMNCH, access to LSCs is included in Uganda's Health Sector Development Plan for the next five years.³⁶

The focus of all activities in grant 2 was on 30 districts in three regions (Busoga, Karamoja, Western) where the mortality burden is high. All regions were represented in the formative research for BCC on family planning. Engagement of pharmacists resulted in LSCs being made available to lower level facilities. In terms of intensity, activities were just the beginning. Some more fragile private entities were "left hanging" when resources came to an end. One respondent felt that one year was adequate for a single focused initiative, but perhaps not for a program of activities. "One year is not realistic."

³⁶ Ministry of Health, The Republic of Uganda. End of Grant Narrative Report to the RMNCH Fund on the Lifesaving Commodities Grant. July 2016.

Documentation of Lessons Learned:

The evaluation team learned that no partners had documented, disseminated or published practices or results at country or regional level. However, several partners felt that there were important experiences to document, but had neither the time nor the resources to do so. Reportedly, Uganda has three well-published studies on misoprostol in home-based management of PPH. Other countries use this data but Uganda has not yet implemented this strategy and is still being debated.

Scaling up with Other Resources:

The Uganda country team identified key areas that were ready for scale-up or roll-out and expected to be covered by the Global Fund or PPP. At the time of the evaluation, respondents anticipated some options for scaling up TF-supported activities with other resources (see Table 19). ICCM opened up other opportunities, such as DFID funding to address the malaria outbreak in Northern Uganda.

Table 19: Uganda: Potential Scale-Up with Alternative Resources

FUND SOURCE	POTENTIAL SCALE-UP
Global Fund	Scale up of ICCM to 63 districts Focused ANC
PPP	Savings from RH voucher project will support scale-up of e-MCH passport

Integration of Unfinished Business into New Strategies and Plans

Uganda was accepted as a 'second wave' GFF country in 2015 and has submitted its investment case. The two basic objectives of the investment case are to (1) improve utilization of essential health services with a focus on RMNCAH services in target districts; and (2) scale-up birth and death registration services. During the field visit, evaluators were informed that this would likely include the following items.

- Quality improvement for maternal health
- RMNCH Balanced Scorecard
- Institutionalization of the MPDSR
- FP tools development
- MH vouchers
- RMNCH service delivery
- Results-based financing
- eLMIS
- Civil registration and vital statistics

Evaluation Question 5: Added Value

To what extent did the RMNCH Trust Fund and related processes contribute to an overall acceleration in progress toward achieving MDGs 4 & 5 in the programme countries. Was the Trust Fund support complementary and catalytic to other sources of investment in RMNCH?

Perceived Catalytic and Complementary Effects

The CEP established collaborative working relationships between the MOH, UN agencies, and implementing partners. Staff and facilities, as well as communities and families benefited through the TF resources and related plans. It supported expansion of MNCH services to high burden and remote areas of Uganda. The voucher system focused on sub-country areas with low numbers of facility births and lower performance and resulted in reduced referrals to higher level facilities because prevention and an increased number of complications could be managed at lower levels of the health system. The introduction of RBF contributed to insights for sustainability and contributed to the GFF investment case. UNICEF leveraged Global Funds to scale up ICCM in-country to 63 districts.

Respondents perceived that the TF had brought significant visibility to the underutilization of LSCs and supported strategies to address this, resulting in increased availability at health facilities. They perceived that TF-supported work is attracting investors in private health care, assisting in the development of new services and strengthening of existing services such as the Uganda Private Midwives Association. They had seen increased uptake of FP services, increased capacity of midwives, and strengthened collaborative relationships with the AOGU. Nineteen districts of Uganda and all regions were represented in the formative FP research which informed the SBCC strategy which may guide FP communications for the next five years. They were particularly pleased about the potential for innovations such as the pre-packaged, color-coded amoxicillin for treating pediatric pneumonia, and the use by VHTs of smartphones to:

- Register each VHT, VHT’s community, community households, and members of the household;
- Monitor mothers’ pregnancy, (postpartum home visits);
- Monitor water and sanitation, and
- Develop a child health platform as well as a medicine and logistics (13 LSC) platform.

Perceived Acceleration of Improved Access

Evidence suggests that there has been an increase in use of facility-based MCH services in high mortality burden areas. For example, in Karamoja, the strategy was to identify the poorest women to support them in accessing services. In 2011, there were 14% of supervised deliveries with 16 midwives and 320 TBAs. In 2016, there were 67% supervised deliveries and 24%–47% ANC.³⁷ Healthy Child Uganda (HCU) reported that systems and the environment for services had been strengthened through innovations such as preparing VHTs to use smartphones in the Community Health Management System (CHMS) by enabling them to register communities, community households and to monitor pregnant women, children, and water/sanitation; conduct home visits, health education, treat infants and children, as well as dispense medicines and maintain community-level LSC logistics. As reported above, Members of Parliament have been engaged and oriented to serve as champions for MCH both within Parliament and with their constituent communities.

The Evaluation Team had no access to data that would indicate outcomes, nor was such data collected by the TF. It is not possible to have a demonstrated impact in such a short timeframe. The TF’s specific intent was to contribute to accelerating achievements of MDGs 4 and 5. For Uganda the goals were to reduce under-five mortality from 187 in 1990 to 62 by 2015 and to reduce maternal mortality from 780 to 200 by 2015. According to the DHS data in Table 20, Uganda fell just short of achieving its target of 62 for under-five mortality, reaching 64. Whilst it has made significant progress since 1990, the maternal mortality ratio, or rather the pregnancy-related mortality ratio (see explanation after the table), has some way to go at 368. Other indicators show trends in the right direction, except neonatal mortality which has remained static.

Table 20: Uganda indicators

INDICATOR	UDHS 2011 ³⁸	UDHS 2016 ³⁹
TFR	6.2	5.4
Teenage childbearing (15-19)	24%	25%
Modern contraceptive use	26%	35%
Unmet Need for FP	34%	28%

³⁷ Source: Assistant District Health Officer, Karamoja Region

³⁸ Source: Uganda Bureau of Statistics (UBOS) and ICF International Inc. *Uganda Demographic and Health Survey 2011*. Kampala, Uganda and Calverton, Maryland. 2012

³⁹ Source: Uganda Bureau of Statistics (UBOS) and ICF. *Uganda Demographic and Health Survey 2016: Key Indicators Report*. Kampala, Uganda and Calverton, Maryland. 2017

Under-five mortality (per 1000 live births)	90	64
Infant mortality rate (per 1000 live births)	54	43
Neonatal mortality (per 1000 live births)	27	27
ANC from skilled provider	95%	97%
Maternal mortality (per 100,000 live births)	-	336
Pregnancy related mortality (for 7 years before each survey, per 100,000 live births)*	438	368

*Previous DHS surveys measure pregnancy-related mortality and not the specific WHO definition of a maternal death: while pregnant, during delivery or in the 42 days after the delivery or within 42 days of termination of pregnancy. Prior estimates of maternal deaths refer to deaths within two months after a birth rather than 42 days after a birth. “Thus, current estimates of maternal mortality are not comparable to estimates from previous MDHS surveys in which only pregnancy-related mortality could be estimated. To assess the trends over time, pregnancy-related mortality was calculated for the 2015-2016 MDHS in the same way that it was calculated in previous MDHS surveys.”⁴⁰

Overleaf:

[Uganda Dashboard](#)

⁴⁰ Ibid. p 248.

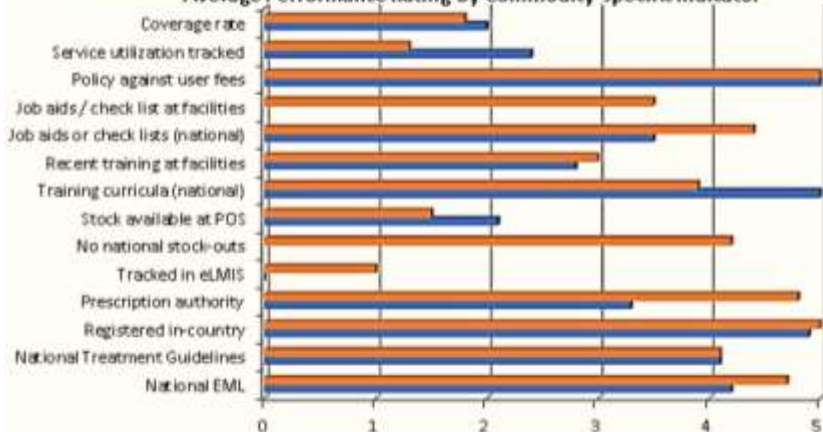
UGANDA

Country Context

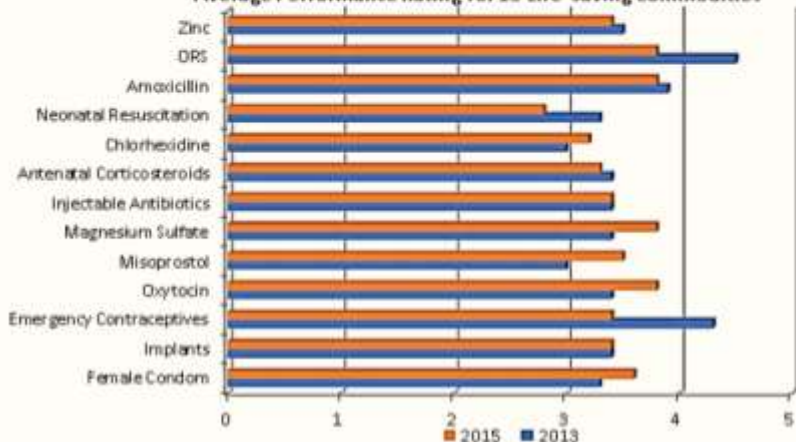
	2012	2015
Total population (000)	36,346	39,032
Total under-five population (000)	6,939	7,278
Total under-five deaths (000)	103	85
Under Five Mortality, per 1,000	69	55
Neonatal deaths (% of under-five deaths)	33	35
Neonatal mortality rate (per 1000 live births)	23	19
Infant mortality rate (per 1000 live births)	45	38
Total fertility rate (per woman)	6.0	5.7
Maternal Mortality Ratio, per 100,000 live births	360	343

Landscape Synthesis Reports

Average Performance Rating by Commodity-specific Indicator



Average Performance Rating for 13 Life-Saving Commodities



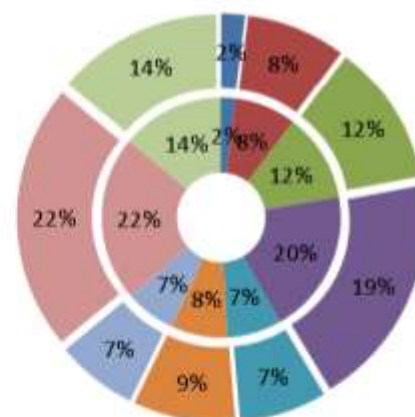
Objectives & Activities

Round 1	Round 2
<ul style="list-style-type: none"> Address supply chain and logistics management systems for 13 LSCs, including awareness/demand, evidence/regulatory issue, provider issues, product development/market shaping 	<ul style="list-style-type: none"> Increased availability, accessibility and utilization of high impact maternal health interventions at birth and during the postnatal period Increased availability access to and utilization of high impact newborn interventions in priority districts Increased treatment coverage for malaria, pneumonia and diarrhea, among children under 5 years in GF supported districts Increased availability and demand for family planning services Improved leadership and governance for RMNCH

Total Budget VS Total Expenditure

Outer Circle: Total Expenditure, Inner Circle: Total Budget

Total Budget: \$8.219.224 Total Expenditure: \$8.294.590



- Infrastructure and Other Equipment
- Advocacy/communication
- Coordination and management
- Human Resources for Health
- Monitoring and Evaluation/Research
- Overheads/Indirect costs
- Policy and guidelines development and/or update
- Procurement and Supply Chain Management (PSM)
- Service delivery

Channelling Agencies

UNICEF
UNFPA
WHO



Implementing Partners

MOH UNICEF, WHO, UNFPA, CHAI, Healthy Child Uganda, AMREF, Helika, m-Health Alliance, Communication for Development Uganda, PATH, Save The Children, Management Sciences for Health Text-4-Change, John Hopkins, World Vision, University Research Council