Evaluation of RMNCH Trust Fund Activities

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ANNEX 1 EVALUATION MATRIX

EVALUATION CRITERIA: RELEVANCE		
Main Evaluation Question: 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? **Questions from the interview guide:** 1. When and how did your organization become involved in the RMNCH TF and what was its role? 2. Did you participate in the identification of bottlenecks and gaps and priorities? If so, please describe the process and outcome? Who was involved in this process? 3. Were any changes made to national plans or the plans of other partners because of this process? Please describe.		
Assumptions	**Indicators**	**Data Sources**
1.1 RMNCH Trust Fund support[1] applied at country level led to: • Engagement of all relevant stakeholders in identifying and prioritizing RMNCH bottlenecks and gaps • Alignment to national plans by other RMNCH stakeholders • The identification of key bottlenecks or gaps in commodities, services and resources relevant to accelerating MDGs 4 & 5 achievements; • A funding request to address them; • An implementation plan, including access to technical resources available; • Alignment to national plans by other RMNCH stakeholders	National prioritization plan from CEP process # and type of bottlenecks and gaps identified Approved funding request Implementation plan and TRT utilized Qualitative or quantitative assessments of bottlenecks/gaps addressed Evidence of change in RMNCH stakeholder plans	Documents • RMNCH Plans • Landscape Analysis • Records of prioritization discussions • Funding requests • Workplans • Synthesis reports • Financial data Interviews • RMNCH Trust Fund partners • SCT • Other RMNCH partners • TRT Online survey

[1] I.e. LSC recommendations, CEP, SCT, Allocation Committee, Grant Funds, TRT

EVALUATION CRITERIA: EFFECTIVENESS

Main Evaluation Question: 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?

Questions from the interview guide: What facilitated or impeded rapid implementation of programme activities supported by the TF?

1. To what extent was the TF global and regional level programming support[2] available, 5utilized and perceived as effective at the country level during grant implementation?
2. To what extent was RMNCH TF technical support received in a timely manner to support program activities?
3. How were the RMNCH TF technical resources used for the greatest benefit to the program with cost-savings?
4. To what extent did Trust Fund support address the three dimensions of sustainable capacity improvement: providers have the Capability, Opportunity and Motivation[3] to effectively provide services?
5. To what extent did providers gain the necessary life-saving skill sets?
6. To what extent did the service environment facilitate performance to national standards?
7. To what extent were providers motivated to incorporated life-saving skills within their overall RMNCH practice?
8. To what extent did TF support effectively address demand for access and use of RMNCH services?
9. To what extent did the program create awareness among communities and potential users of expanded RMNCH services that include life-saving practices?
10. To what extent did the program address barriers to use among communities and potential users of expanded RMNCH services that included life-saving practices?

Assumptions	Illustrative Indicators	Data Sources
2.1 Processes and procedures were established at global, national and sub-national levels to facilitate effectively the • Disbursement of Trust Fund funds • Rapid programme implementation at the country level given the short duration of the project [4] • Access to global and regional programming support during implementation • Outputs that can be qualitatively or quantitatively assessed.	• Time from request of funds to disbursement • Workplans indicate timeline for implementation • Reports indicate compliance with timeline • Technical support available and utilized • Outputs documented	Document Review • Workplans • Reports • National health accounts data • Program data Interviews and discussions • RMNCH Trust Fund Partners • Trust Fund Manager • Requisition staff • SCT • Sub-national Managers Online survey Stakeholders in 14 countries

[2] Programming support encompasses planning, financial, technical, M&E.

[3] Michie *et al.*

[4] Includes country engagement process, gap analysis, prioritization process, global and regional technical support from SCT, TRTs, and Allocation Committee, guidelines and tools, etc.

2.2 Trust Fund supported interventions addressed the three dimensions of sustainable capacity improvement: **providers** have the Capability, Opportunity and Motivation to effectively provide RMNCH services (positive behaviour change).	• Program documents and experience of managers confirm gains in skills and competencies verified by follow-up and supervision • Documents objectively identify how the program addressed gender and the needs of users, including vulnerable and marginalized groups • Views of health facility staff • Views of community members	Document • District level data on RMNCH use at subnational levels for the period of implementation • Subnational monitoring and supervision visit reports by health authorities • Training and procurement reports Interviews • RMNCH Trust Fund partners • SCT • National/sub-national health authorities • Site visits • Health facility staff • Community representatives Online survey • Stakeholders in 14 countries
2.3 Trust Fund supported interventions addressed the three dimensions of sustainability capacity improvement: users have the Capability, Opportunity and Motivation to effectively demand and use RMNCH services (including marginalized and vulnerable groups)	• Trends in data on use of RMNCH service at national and sub-national levels • Views of health facility staff and community members • Documents reflect advocacy and demand generation initiatives • Documents objectively identify how the program addressed gender and the needs of users, including vulnerable and marginalized groups • Views of users of RMNCH services	Document Review • National/District level data on RMNCH service use for the period of implementation • Review of workplans Interviews and discussions • RMNCH Trust Fund partners • Site visits • Health facilities staff • Community representatives Online survey • Stakeholders in 14 countries

EVALUATION CRITERIA: EFFICIENCY

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

Questions from the interview guide:

1. How did the TF process help the MOH and development partners align or harmonize RMNCH plans during planning, implementation and monitoring at national and sub-national levels?
2. With multiple partners financially or programmatically supporting the national health plans, how was duplication avoided at national and sub-national levels?
3. How were districts engaged in the process of identifying gaps, prioritization, planning and implementation?
4. What factors affected the program's ability to efficiently utilize TF funds for implementation?
5. How efficiently were TF inputs sequenced to support improvements in service readiness and demand creation?
6. What factors facilitated or hindered timely disbursement of funds from central to national level and then from national to sub-national level?
7. Of the priorities identified to address bottlenecks and gaps, what was completed on time with Trust Fund support? What remains unfinished?
8. Were all priorities identified addressed by support from the RMNCH TF? If yes, what documentation do you have to demonstrate this? If no, were they addressed through some other resources, and if so what?

Assumptions	Illustrative Indicators	Data Sources
3.1 RMNCH TF partners and other RMNCH partner plans, TA, and activities were coordinated to address priority bottlenecks and gaps at the national and sub-national levels without duplication.	• Presence of partner coordination mechanism to harmonize funding, technical support, and program oversight consistent with country RMNCH priorities. • Identified bottlenecks, gaps, and their prioritization. • Mapped partner/donor/domestic resources to be accessed. • Consensus among stakeholders that interventions filled identified RMNCH gaps. • Workplans incorporate links to other RMNCH programs • Identification of partner synergies from coordinated programming planning.	Documents • Landscape analysis report • RMNCH Plans • Records of 7 prioritization discussions • Workplans (joint or linked) Interviews • RMNCH Trust Fund partners • SCT • Other RMNCH partners, including MOH • TRT Online Surveys National/sub-national, RMNCH/donor partner stakeholders in 14 countries

3.2 The implementation of Trust Fund inputs was well sequenced to support improvements in service readiness and demand creation.	• Time between funds requested and funds disbursement. • Time between funds disbursement and implementation of activities. • Presence of internal processes delaying or facilitating on-time disbursement of funds. • Presence of internal processes delaying or facilitating on-time completion of activities. • On-time completion of workplan activities.	Documents • Funding requests • National/sub-national workplans • Monitoring meetings reports (implementation, coordination, course correction) • National/sub-national accounting of implementation activities Interviews • RMNCH Trust Fund Partners • SCT • Other RMNCH Donors • Sub-national Managers Online Surveys • National/sub-national, RMNCH/donor partner stakeholders in 14 countries
3.3 RMNCH TF funding and technical support were flexible and responsive to national/sub-national needs.	• TF inputs [5]sequenced consistent with national/sub-national needs and coordinated workplans. • Resource deficit or surplus identified against implemented activities. • Programme review and operational planning processes include participation by district and health facilities level staff • Annual operational plans respond to stated priorities of local service providers. • Presence of link between sub-national activities monitoring against implementation plan.	Documents • National products (training, supervision, job aids/tools) • Coordination meeting minutes identifying priorities and sequencing of interventions • Workplans (national/sub-national) • Fund requests (timing of) and fund release • Accounts management (deficit/surplus against activities) Interviews • RMNCH Trust Fund Partners • SCT • Procurement and Commodities Managers • TRT members • Training institutions • National/sub-national

[5] e.g., guidelines, commodities, equipment and materials, training, supervision, job aids and tools etc.,

		health accounts officers • National/sub-national supervisors Online Surveys • Program, technical, stakeholder in 14 countries.
3.4. Alternative sources of funding (domestic/international) were identified to address bottlenecks or gaps not funded by the Trust Fund.	Additional funding identified: • Source • Amount • To be applied to • Proportional to gaps identified	Documents • RMNCH Plans • Landscape Analysis • Records of prioritization discussions • Proposals to other donors • Synthesis reports • Financial data Interviews • RMNCH Trust Fund partners • SCT • Other donors Online survey

EVALUATION CRITERIA: SUSTAINABILITY

Main Evaluation Question: 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?

Questions from the Interview Guide

1. What evidence exists that supported activities were of sufficient intensity, reach and duration to contribute to sustained changes in service readiness and demand generation?
2. To what extent have good and bad practices been systematically documented and disseminated at country and regional levels to enhance RMNCH implementation? In processes used to support planning? In programmatic interventions applied?
3. To what extent have additional or new financial (domestic or external) and human resources been committed to maintain results within the national health system?
4. To what extent have RMNCH TF supported interventions been scaled up with alternative resources and programming support?
5. To what extent have efforts been made to integrate unfinished business into new strategies and plans (e.g. Ministry of Health (MoH), GFF, or other donors)

Assumptions	Indicators	Data Sources
4.1 RMNCH Trust Fund activities had sufficient reach, intensity and duration to contribute to and sustain changes in service readiness and demand generation	• Reach of Trust Fund supported interventions • Intensity of Trust Fund supported interventions • Duration of Trust Fund supported interventions • Views of sub-national managers • Views of health facility staff • Views of community	Documents • Workplans and results reports at country level • Data on service use • Training data • Commodities data Interviews • Sub-national managers • Site visits • Health facilities staff • Community members Online survey Stakeholders in 14 countries
4.2 Lessons learned, including good and bad practices, have been systematically documented and disseminated at country and regional levels to enhance RMNCH implementation.	• # and type of research studies implemented • national plans incorporate lessons learned and plans for scale-up where appropriate • # dissemination events	Documents • Evaluation and research study protocols and study reports • National RMNCH plans • Reports of dissemination meetings Interviews • Views of national and international stakeholders Online survey Stakeholders in 14 countries
4.3 RMNCH Trust Fund supported interventions have been scaled up with	• # and type of interventions replicated in other areas (subnational, regional)	Documents • National RMNCH budget or budget within national

alternative resources and programming support.	• New funding sources identified • Additional funds received to support replication • National budgetary commitment • Identifiable features of the TF supported interventions are replicated/adopted in other programmes of support to RMNCAH including (for example) Results Based Financing initiatives.	health account • Requests to donors/ proposal documents • SDG plans • If appropriate, requests to GFF Interviews • RMNCH Trust Fund partners • SCT • Bilateral and multilateral donors • International and national NGO representatives Online survey Stakeholders in 14 countries
4.4 An explicit exit strategy was developed to address how supported interventions would be sustained, including both alternative sources of funding and support to interventions aimed at building durability into RMNCH services.	• Exit strategy reflected in final documents/reports • Identification of alternative resources • Identification of alternative programming support	Documents • Final reports • National health accounts • Donor commitments • Workplans/budgets Interviews • RMNCH partners • Donors Online survey Stakeholders in 14 countries

EVALUATION CRITERIA: ADDED VALUE (Impact)

Main Evaluation Question: 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?

Questions from the interview guide:

1. How catalytic was the RMNCH TF initiative towards achieving MDGs 4 & 5?
2. How complementary was the RMNCH TF support?
3. How well did the RMNCH TF coordination succeed in gap-filling to move the national priorities toward achieving MDGs 4 & 5?
4. What evidence do you have to indicate that women and children have increased use of RMNCH health services because of this program?
5. What do national stakeholders perceive to be the strengths and/or weaknesses of the RMNCH TF?
6. What has been the most significant result of the RMNCH TF in this program?

Assumptions	Indicators	Data Sources
5.1 RMNCH Trust Fund supported activities were **catalytic**, leading to leveraged funding or a larger program to accelerate achievement of MDG 4&5.	• Source and amount of funding leveraged • Scale up/expansion of interventions to additional geographic areas	Documents • Reports • National health accounts • Donor commitments • Workplan/ budgets Interviews • RMNCH partners • Donors Online Survey Stakeholders in 14 countries
5.3 RMNCH TF supported activities are perceived to have contributed to improved access to and use of interventions that would lead to accelerated achievements of MDGs 4&5.	• Views of RMNCH TF partners from national health authorities to facilities staff.	Document review • Landscape Analysis • Synthesis reports • National RMNCH plans and budget • Proposals to GFF or donors Interviews • RMNCH partners • Other donors Online survey

ANNEX 2 CAUSAL ASSUMPTIONS TO THEORY OF CHANGE

Level 1:
Assumptions at this level imply that the recommendations of the November 2013 guidance document, *Toward a Common Country Engagement Process,* were followed. These included a joint rapid multi-stakeholder synthesis of the RMNCH landscape; prioritisation of actions; and commitment of development partners to support implementation of prioritised interventions under the leadership of the relevant ministry and to build on other major planning processes. Through this coordinated RMNCH planning, bottlenecks and gaps were identified and priorities were defined.

LEVEL	ASSUMPTION	OECD DAC CRITERIA
1	1.1 RMNCH Trust Fund support applied at country level led to: 1.1.1 Engagement of all relevant stakeholders in identifying and prioritizing RMNCH bottlenecks and gaps 1.1.2 The identification of key bottlenecks or gaps in commodities, services and resources relevant to accelerating MDGs 4&5 achievements 1.1.3 A funding request to address them 1.1.4 An implementation plan, including access to technical resources 1.1.5 Alignment to national plans by other RMNCH stakeholders	Relevance

Level 2: Assumptions at this level imply that the funding requests reflected the identified bottlenecks or gaps, that attempts were made to identify additional resources to be brought to bear on prioritised interventions to address the bottlenecks and gaps and that the output was a rationalised funding plan.

LEVEL	ASSUMPTION	OECD DAC CRITERIA
2	2.1 Processes and procedures were established at global, national and sub-national levels to facilitate effectively the: 2.1.1 Disbursement of TF funds	Effectiveness
	3.1 RMNCH TF partners and other RMNCH partner plans, TA and activities were coordinated to address priority bottlenecks and gaps at the national and sub-national levels without duplication. 3.4 Alternative sources of funding were identified to address bottlenecks or gaps not funded by the TF.	Efficiency

Level 3: Assumptions at this level imply that priorities were reflected in a coordinated, efficient program to strengthen health systems and to address demand generation effectively.

LEVEL	ASSUMPTION	OECD DAC CRITERIA
3	2.1.2 Rapid programme implementation at the country level given the short duration of the project	Effectiveness

	2.1.3 Access to global and regional programming support during implementation	
	3.2 The implementation of TF inputs was well sequenced to support improvements in service readiness and demand creation 3.3 RMNCH TF funding and technical support were flexible and responsive to national/sub-national needs	Efficiency

Level 4: Assumptions at this level address the behaviour change effectively brought about by strengthening systems and addressing demand generation.

LEVEL	ASSUMPTION	OECD DAC CRITERIA
4	2.2 Trust Fund support addressed the three dimensions of sustainable capacity improvement: providers have the *capability, opportunity* and *motivation* to effectively provide quality RMNCH services. 2.3 Trust Fund support addressed the three dimensions of sustainable capacity improvement: users have the *capability, opportunity* and *motivation* to effectively demand and use RMNCH services. 2.1.4 Outputs that can be qualitatively or quantitatively assessed	Effectiveness
	4.1 RMNCH TF activities had sufficient reach, intensity and duration to contribute to and sustain changes in service readiness and demand generation 4.2 Lessons learned, including good and bad practices, have been systematically documented and disseminated at country and regional levels to enhance RMNCH implementation 4.3 RMNCH TF supported interventions have been scaled up with alternative resources and programming support 4.4 An explicit exit strategy was developed to address how supported interventions would be sustained, including both alternative sources of funding and support to interventions aimed at building durability into RMNCH services.	Sustainability

Level 5: Assumptions at this level address the overarching question: to what extent did the RMNCH Trust Fund add value for the future operationalisation and implementation of the Global Strategy and the Global Financing Facility.

LEVEL	ASSUMPTION	OECD DAC CRITERIA
5	5.1 RMNCH Trust Fund supported activities were catalytic leading to leveraged funding or a larger program to accelerate achievement of MDG4&5 5.2 RMNCH TF supported activities are perceived to have contributed to improved access to and use of interventions that would lead to accelerated achievements of MDGs 4&5.	Added Value

ANNEX 3 LIST OF DOCUMENTS REVIEWED

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USAID, PEPFAR, Saving Mothers, Giving Life, Helath Policy Project. January 2014 (Uganda)

Visite de la mission conjointe RMNCH au Burkina Faso pour discuter du processus d'engagement RMNCH des pays, 22-23 April 2014

WHO, The World Bank, Allliance for Health Policy and Systems Research, The Partnership for Maternal, Newborn, and Child Health. September 2014. Success Factors for Women's and Children's Health: how some countries are accelerating progress towards MDGs 4 and 5 (Uganda)

General list of documents:

Grant documents:

- Original proposal/fund request
- Budgeted work plans
- Quarterly and annual reports
- Landscape analysis reports (and references, when available)
- Country-level M&E framework for the grants
- Updated M&E framework illustrating progress on indicators (if available)

Coordination/management/TA:

- Minutes of coordination/planning/ review meetings at national level (related to the Trust Fund)
- Minutes of workshops/conferences (related to the Trust Fund)
- Reports of joint field missions (in-country H6/MoH team responsible for coordinating/overseeing the RMNCH Trust Fund grants)
- Reports of field missions of SCT or international consultants to the country (I recall that the SCT hired international to assist with the CEP process in several countries?)
- Any other report or meeting minutes that illustrates interaction between the global/regional and the country level.

Research/data in general:

- Baselines studies (RMNCH Trust Fund specific or general) – such as EmONC baseline (available in many countries)
- HMIS data at district level (if not available in M&E documentation of the RMNCH Trust Fund) – on key programme indicators
- DHS and MICS
- Any other relevant research studies (QUAL) or surveys (QUANT)

National policies and strategies:

- National Strategic Plans related to pharmaceuticals/supply chain management
- RMNCH Road Map or Investment Case (if available)
- Any GFF related documents
- National Health Sector Development Plan

Activity related (mostly relevant for field mission countries):

- Training reports (pre- and post-test available?)
- Post-training supervision reports or general supervision reports (district/facility level)
- Quarterly and annual reports of implementing partners (these often provide more detail, especially on challenges, than the compiled/consolidated country annual report)

ANNEX 4 PEOPLE MET AND INTERVIEWED

NAME AND TITLE	ORGANIZATION	Position
CAMEROON		
Dr. Martina Baye	Ministry of Public Health	Coordinator, National Program to Combat Maternal and Child Mortality
Mrs. Magele Gertrude Lydie	Ministry of Youth Affairs	Director, CPJA
Nicole Eteki	UNFPA	Reproductive Health Specialist
Belyse Ngum	UNICEF	Health Specialist
Mr. Daniel Sibetcheu	OFSAD (NGO)	Executive Director
DRC		
Dr Mukengeshayi Kupa Marcel	Ministère de la Santé Publique	Secrétaire Général
Prof. Chenge Faustin	Ministère de la Santé Publique	Ancien Directeur de Cabinet du Ministre
Dr Kalume Tutu Baudouin	Ministère de la Santé Publique	Directeur, Direction Santé de la Famille et des Groupes Spécifiques
Ph. Ngeleka Mutolo Daniel	Ministère de la Santé Publique	Directeur, Direction de la Pharmacie et des Médicaments
Dr Mboko Iyeti Alain	Ministère de la Santé Publique	Directeur, Direction des Études et Planification et Coordonnateur du PDSS
Dr Kyungu Banza Marie-Thérèse	Ministère de la Santé Publique	Directrice du Programme National de la Santé de la Reproduction
Dr Mithano Lamy	Ministère de la Santé Publique	Directeur Adjoint, Programme National de la Santé de la Reproduction
Wembo Ndjadi Jean de Dieu	Ministère de la Santé Publique	Chef de Division Administrative et Financière, Programme National de la Santé de la Reproduction
Ph. Bola Léonie	Ministère de la Santé Publique	Chef de Bureau chargé des Commodités
Kakez Kayombo Cristiano	Ministère de la Santé Publique	Directeur, Programme National pour la Promotion des Mutuelles de Santé
Dr Allangar Yokouide	OMS	Représentant
Dr Lokonga Jean-Pierre	OMS	MNP
Dr Kini Nsiku Brigitte	OMS	
	UNFPA	Représentant adjoint
Lordfred Achu	UNFPA	Conseiller Technique Principal en santé Reproductive, Maternelle et Néonatale
Kamanda Jean-Claude	UNFPA	
Ali Wanago	UNFPA	
Guy Clarisse	UNICEF	Chef de section Survie de l'enfant

Dr Tony Byamungu	UNICEF	
Dr Kazadi Ntita Thierry	UNICEF	Spécialiste Santé RSS
Laviolette Luc	BANQUE MONDIALE	Coordonnateur de Programmes Développement humain
E. De Baker	Ambassade de Belgique	Chef de la Coopération
Eric Vanbeveren	Ambassade de Belgique	Conseiller Coopération au Développement
Annie Simard	Ambassade du Canada	Première secrétaire (coopération)
Dong Eun Shin	KOICA	Chef de Projet Santé de la mère et de l'enfant dans le district de Kwango
Dr Munyeku Yannick	KOICA	Chargé de programme de santé
Dr Lubemba Claudel	KOICA	Projet Santé de la Mère et de l'enfant Kwango
Michie Takasu	JICA	Directrice programme Santé
Dr Mufwaya Nsene Raymond	JICA	Directeur Adjoint programme santé chargé des secteurs Santé, Eau et Assainissement
Albert Chikuru	ASF	Directeur Santé de la Reproduction
Kasongo Mankie Gaby	ASF	Directrice Santé Maternelle et Infantile
Mangungu Paulin	CAMESKIN	Directeur
Ph. Mulongo Banana Ruphin	MSH	Directeur de Projet SIAPS
Ph. Massamba	MSH	Conseiller Technique
Dr Binanga Arsène	Tulane International	Directeur des Projets de Planning Family
Christophe Tocco	USAID	Représentant pays
Dr Kiangala Claude	Ministère Provinciale de la Santé	Ministre Provincial de la Santé
Dr Mwela Pierre	Division Provincial de la Santé	Chef de Division Provincial de la Santé
Dr Hata Freddy	Division Provincial de la Santé	Membre de la Division Provinciale de la Santé
Dr Kabadi Papy	Division Provincial de la Santé	Membre de la Division Provinciale de la Santé
Dr Nkinzi Anaclet	Zone de Santé de Kenge	Médecin Chef de Zone
Nimi Jeancy	Zone de Santé de Kenge	Infirmier Superviseur
Mitondo Michée	Zone de Santé de Kenge	Infirmier Superviseur
Mutabu Jean	Zone de Santé de Kenge	Secrétaire
Mishidi Djenny	Zone de Santé de Kenge	Administrateur Gestionnaire
Munongo Flory	Zone de Santé de Kenge	Animateur Communautaire
Mulandu Gisèle	Zone de Santé de Kenge	Animatrice Communautaire
Mayamba Alliance	Zone de Santé de Kenge	Préposée à la Pharmacie
Matondo Yamfu Prudent	Zone de Santé de Kenge	Nutritionniste
Idima Willard	Zone de Santé de Kenge	Infirmier Superviseur
Mankasi Darry	Zone de Santé de Kenge	Infirmier Superviseur
Kambamba Nkosi	Zone de Santé de Kenge	Administrateur Gestionnaire
Kusedika Wivin	Zone de Santé de Kenge	Administrateur Gestionnaire

Tsumbu Gobe	Zone de Santé de Kenge	Administrateur Gestionnaire
Dr Castellam Chiari	Zone de Santé de Kenge	Directrice du Bureau Diocésain des Œuvres Médicales (Église Catholique)
Dr Lukandu A. Marc	Zone de Santé de Kenge	Médecin Directeur HGR Kenge
Dr Kombo Emmanuel	Zone de Santé de Kenge	Médecin traitant
Kibanda Zacharie	Zone de Santé de Kenge	Directeur de Nursing
Lukula Bitumba	Zone de Santé de Kenge	Secrétaire
Mfutila Léonie	Zone de Santé de Kenge	Administrateur Gestionnaire
Lufungula Françoise	Zone de Santé de Kenge	Responsable de la Maternité
Munongo	Zone de Santé de Kenge	Infirmier Titulaire CS CBCO
Mbalanda Joseph	Zone de Santé de Kenge	Infirmier Titulaire CS Pont Wamba
ETHIOPIA		
Gamachis Galalcha	UNFPA	Programme Analyst (FP/RHCS)
Wegen Shiferaw Shirka	WHO	
Dr Zelalem Demeke	CHAI	
Berhane Assefa	MOH	RMNCH
Dr. Lisanu Taddesse	MOH	Child Health
Dr. Hailemariam	UNICEF	
MALAWI		
Dr. Fanny Kachale,	MOH	Director, Reproductive Health Directorate
Dr. Milika Mdala,	UNFPA	RHCS Specialist
Anatfu Getachew,	UNICEF	MNH Specialist
Mr. Samuel Chirwa,	UNICEF	Consultant, Immunization Supply Chain Specialist
Dr. Harriet Chonza	WHO	
Dr. Magalula	WHO	
Mr. Gunda Andrews W.,	CHAI	Country Director
Mr. Philip Kamutenga,	Chemonics (formerly JSI)	Country Director
Boss Mwafulirwa	Liverpool School of Tropical Medicine	Senior Technical Officer
Sheila Banda	LSTM	Program Officer
Cecilia Cruz	LSTM	Program Coordinator
Christa	LSTM	Financial Accountant
Jacqueline Mwanga	Mai Kande	
Ms. Rosemary Kambewa,	Malawi Health Equity Network (MHEN)	Program Manager, Governance Section
Mr. Kenasi Kasinje,	MSH	Program Manager, DHPI
Dr. Isabel Kazanga	MSHY	Consultant
Charles Makwenda,	PACHI	Country Director
Hilda Chapota	PACHI	RMNCH Project Coordinator
NIGER		
Aminata Tinni KONATE	Ministère de la Santé Publique, Direction de la Santé de la Mère et de l'Enfant (DSME)	Chef de Division Santé Néonatale et Infantile
Dr Abdoulkarim Adama KEMOU	Ministère de la Santé Publique, Direction de la Santé de la	Directrice de la Santé de la Mère et de l'Enfant

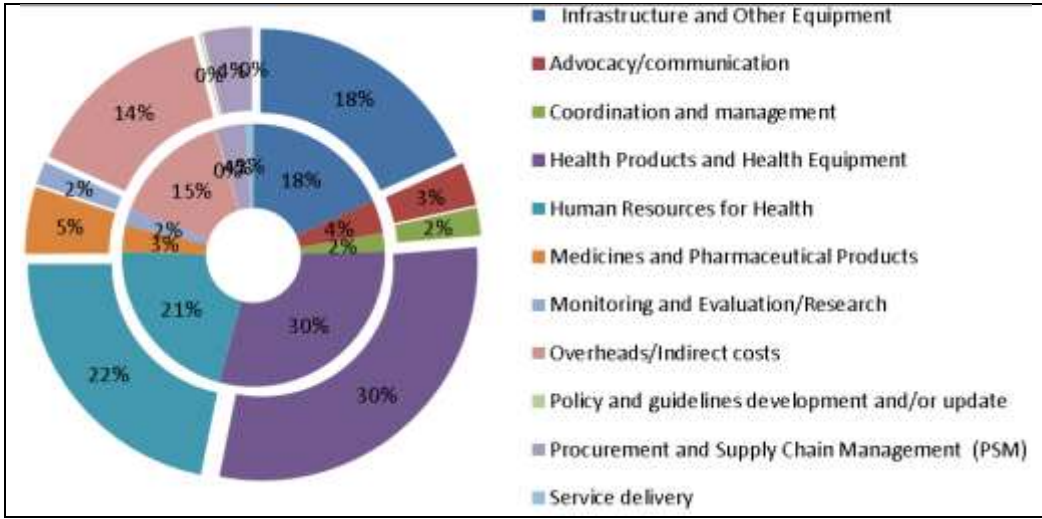
	Mère et de l'Enfant (DSME)	
Marie MARCOS	UNICEF	Maternal & Child Health Specialist
Dr Touré Hamadassalia	UNICEF	Chef de Section de la Survie
NIGERIA		
Dr. Ngozi Franca Njoku	National Primary Health Care Development Agency	Grant Focal Point
Dr. Andrew Mbewe	WHO	WHO Focal Point (since start)
Olufunke Fasawe	Clinton Health Access Initiative	RMNCH Focal Point
PAKISTAN		
Dr Jamil Ahmad Chaudry	UNFPA	National Program Technical Specialist (RH/FP)
Dr Samia Rizwan	UNICEF	Health Specialist MNCH, UNICEF Islamabad
Dr Lamia Mahmoud	WHO	Medical Officer RMNCAH and Nutrition; Cluster Lead, Promoting Health through Lifecourse, WHO Pakistan Country Office
Dr Sabeen Afzal	MONH	Deputy Director (Programs)
MONHS, Regulation and Coordination		
TANZANIA		
Ms Felister Bwana	UNFPA	Country Focal Point RMNCH Trust Fund,
Programme Specialist		
Dr Rutasha Dadi	UNFPA	Ex-country Focal Point RMNCH Trust Fund, Assistant Representative UNFPA
Dr Victor Bakaengesa	MOHSW	MOHSW coordinator/Focal Point RMNCH Trust Fund
Dr Koheleth Winani	MOHSW	National Coordinator SMI, Ag Head of RCHS
Dr Theopista John Kabuteni	WHO	WHO Focal Point RMNCH Trust Fund, National Program Officer/FHP
Dr Asia Kassim Hassan	UNICEF	UNICEF Focal Point RMNCH Trust Fund
Dr Sudha Sharma	UNICEF	Chief Health and Nutrition Team
Mr Fredrick Sheshe	UNICEF	Supplies Officer
Dr Herbert George Masigati	MOHSW	Medical Officer in Charge, Shinyanga Regional Hospital
Dr Neema Rusibamayila	MOHSW	Director Preventive Services
Dr Chibole Mpelembe	PORALG	Health Services Administrator in President's Office
Dr Rita Noronha	AMREF Health Africa	Country Director
Dr Serafina Mkuwa	AMREF Health Africa	Program Manager
Mr Christopher Migoha	TFDA	Principal Drugs Evaluator /Registration and Regulatory Officer

Mr Marasi Mwencha	JSI	Deputy Chief of Party /USAID Global Supply Chain Contractor
Dr Mtumwa Ibrahim	MOHZ	Manager, Integrated Reproductive and Child Health Programme
Ms Sharifa Awadh Salmin	MOHZ	RMNCH Trust Fund Focal Point
Mr Peter Riwa		Local Consultant Tanzania RMNCH Trust Fund
Dr Christine Mwanukuzi-Kwayu	UNFPA	Assistant Representative
Dr Richard Banda	WHO	Acting Country Representative
UGANDA		
Hon. S. Opendi (MP	MoH	Minister of Health
Prof. A. K. Mbonye,	MoH	Focal Point
Dr. D. Nakiganda,	MoH	A Comm. RH
Dr. P. Kaggwa, ,	MoH	A. Comm. HED
Mr. M. Seru,	MoH	Pharmacy
Dr. John Bosco, Kyankwanzi	MoH/ DHOs (Mayuge, Kamuli, Karamoja) Western region	
Dr. John Twyaganuka, Masindi		
Dr. Johnson Sabagabo, Kaliro		
Dr. James Lemukol, Napak		
Dr. Charles Nabangi, Mayuge		
Dr. Henry Karende	Mayuge (field)	Administrator, St. Francis, Buluba Hospital
Dr. Henry Karende,	MoH, Mayuge	Administrato, St. Francis Buluba Hospital r
Dr. Andrew Muleledhu,	MoH, Kamuli General Hospital	Administrator
Mary Magowa,	MoH, Kamuli General Hospital	Midwife
Dr. Andrew Muleledhu,	MoH	Administrator, Kamuli Mission Hospital
Mary Magowa,	MoH	Midwife, Kamuli Mission Hospital
Ms. M. Tabifor, ,	UNFPA	Deputy Representative
Dr. Y. Mugerwa,	UNFPA	RMNCH Focal Point
Dr. Edison H. Muhwezi	UNFPA	Assistant Representative
Mr. L. Were	UNFPA	Pharmacy
Dr. O. Sentumbwe	WHO	
Dr. V. Masembe	WHO	
Mr. J. Mwoga	WHO	Pharmacy
Dr. O. Sentumbwe	WHO	
Ms. A. Girma	UNICEF	Country Representative,
Dr. G. Latigi	UNICEF	
Dr. F. Mpanga Kaggwa	, UNICEF & Team	UGD/ESAR Health Specialist
DR. Viorica Berdaga	UNICEF	Chief Child Health Survival & Development

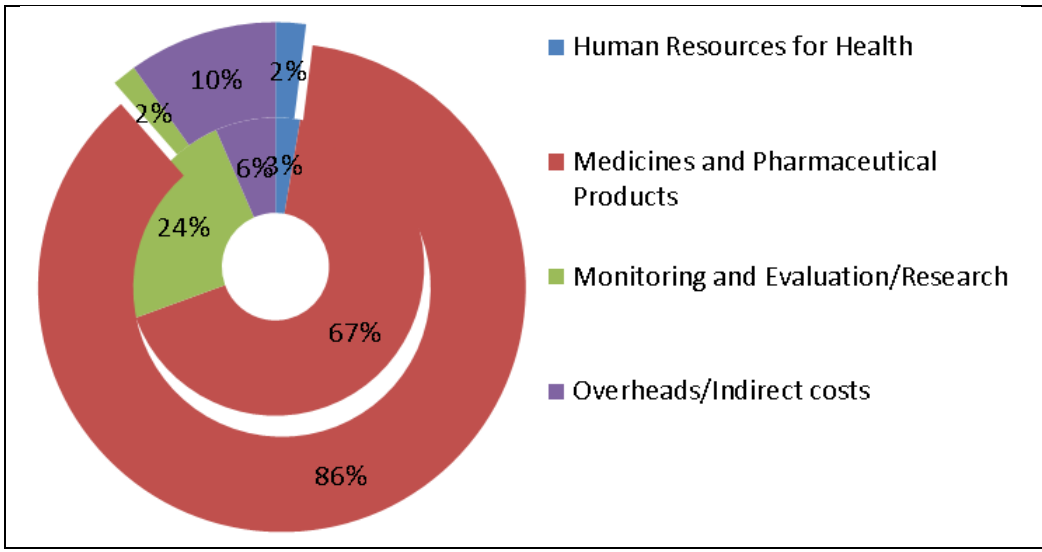
Dr. Kumbakumba,	UNICEF	MUST
Christine Mugasha,	USAID	Program Management Specialist (MCH)
Sheila Nyakwezi,	USAID	Program Management Specialist, Nutrition
Dr. C. Sekimpi,	Marie Stopes Uganda (MSU)	
W. Nyombi	MSU	Program Manager
J. Kemigisha	CDFU	Project Coordinator, Healthy Choices
Dr. F. Kaharuza,	Association of Obstetricians & Gynecologists of Uganda (AOGU)	
D. Namuyobo	Reproductive Health Unit Uganda (RHU)	Medical Coordinator
A. Lutwama,	Info Systems	
Ms. H. Karamagi,	HELIKA	
Mr. D. Kirchhoffer	CHAI (formerly)	
Ms. R. Lukwago	DFID	
Dr. Patrick T. Kagurusi,		Head of Programs, Technical Advisor, RMNCAH
Doreen Kisembo	World Vision International (formerly)	
Joab Tusaasire	World Vision	International, Nutrition Specialist
Dr. Peter Okwero	World Bank Country Office	Senior Health Specialist
Mr. Damien Kirchhoffer,	IPA (formerly CHAI)	
Ms. Susan Eckey	Norwegian Embassy	Ambassador
Ms. Nadia El Ouargui	NORAD	

ANNEX 5 BUDGET VERSUS EXPENDITURES BY COUNTRY

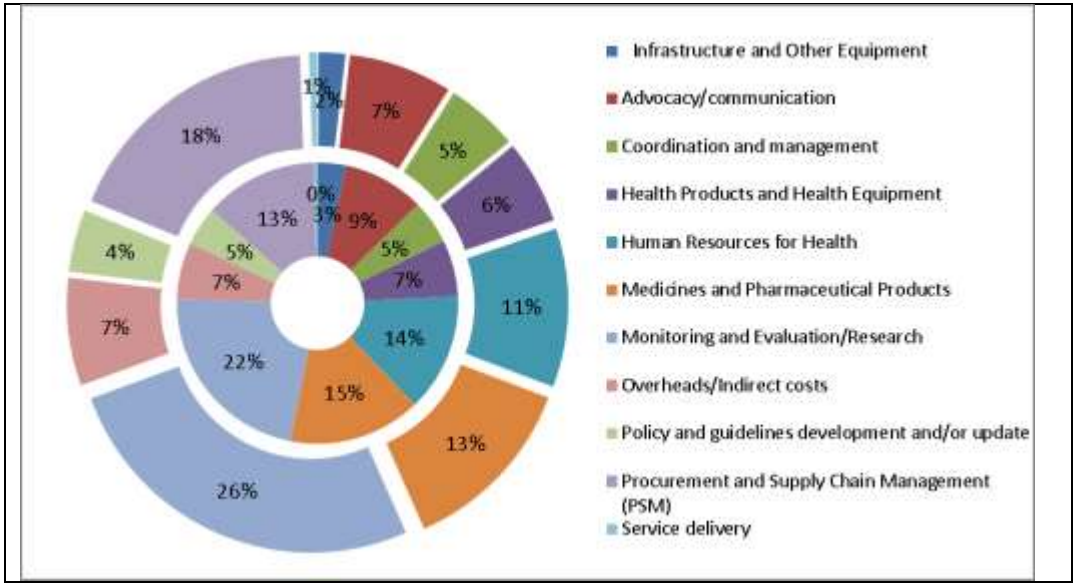
Afghanistan	Budget	Expenditure
Infrastructure and Other Equipment	1,408,000	1,430,602
Advocacy/communication	318,820	256,820
Coordination and management	174,000	165,272
Health Products and Health Equipment	2,296,700	2,306,700
Human Resources for Health	1,643,872	1,704,979
Medicines and Pharmaceutical Products	257,500	393,777
Monitoring and Evaluation/Research	149,500	137,500
Overheads/Indirect costs	1,125,713	1,125,713
Policy and guidelines development and/or update	15,000	14,000
Procurement and Supply Chain Management (PSM)	288,000	288,000
Service delivery	70,450	-
	7,747,555	**7,823,363**



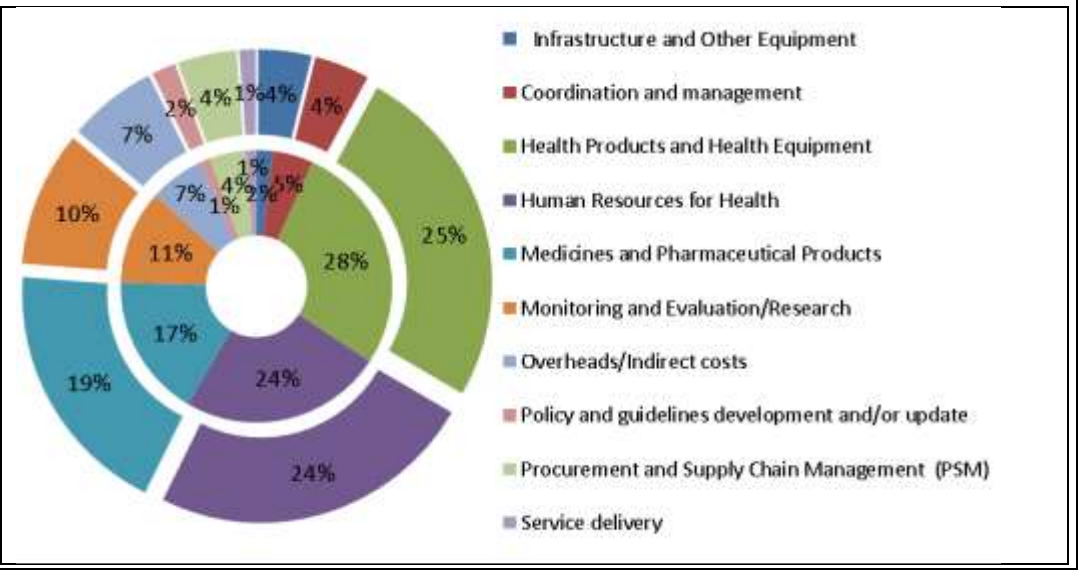
Bangladesh	Budget	Expenditure
Human Resources for Health	20,000	10,000
Medicines and Pharmaceutical Products	500,000	430,000
Monitoring and Evaluation/Research	180,000	8,000
Overheads/Indirect costs	49,000	49,000
	749,000	**497,000**



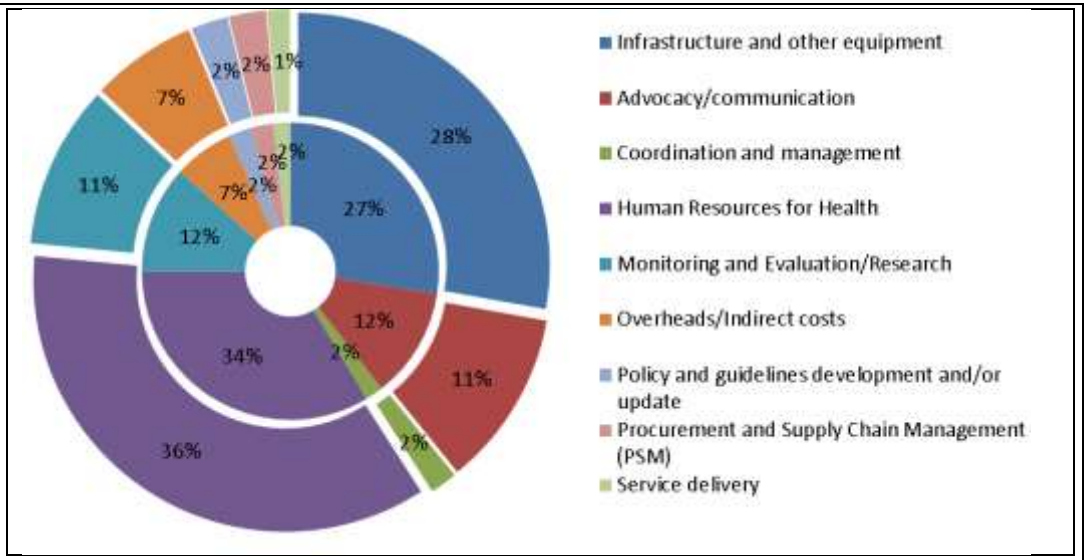
Benin	Budget April 2017	Expenditure
Infrastructure and Other Equipment	130,000	65,251
Advocacy/communication	374,000	251,732
Coordination and management	203,425	176,984
Health Products and Health Equipment	257,800	204,613
Human Resources for Health	543,419	386,300
Medicines and Pharmaceutical Products	609,000	443,854
Monitoring and Evaluation/Research	891,586	918,822
Overheads/Indirect costs	261,682	261,682
Policy and guidelines development and/or update	180,000	151,973
Procurement and Supply Chain Management (PSM)	520,588	643,733
Service delivery	18,000	19,782
	3,989,501	**3,524,726**



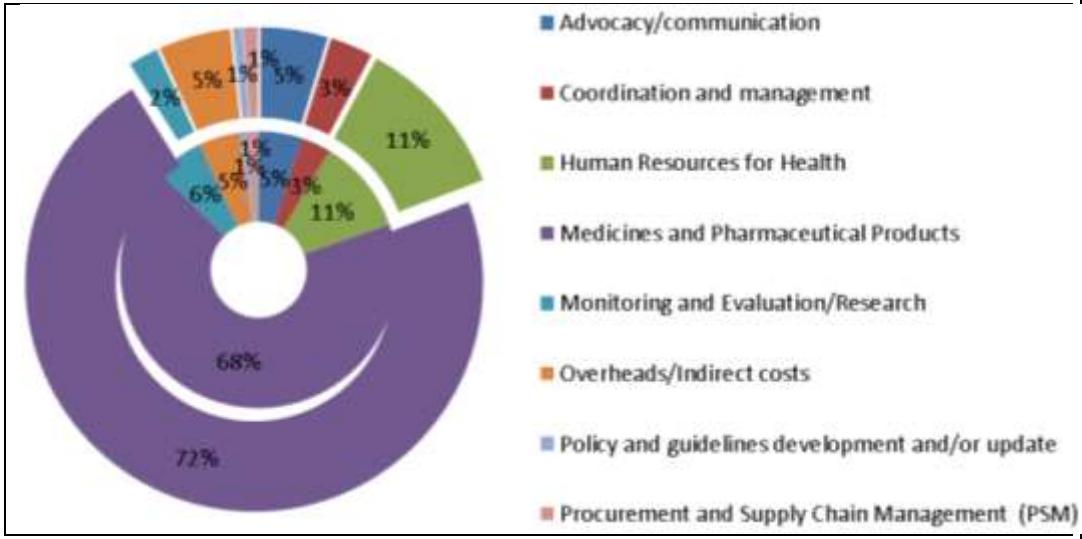
Burkina Faso	Budget	Expenditure
Infrastructure and Other Equipment	100,000	197,957
Coordination and management	246,433	205,651
Health Products and Health Equipment	1,398,270	1,290,517
Human Resources for Health	1,227,909	1,215,770
Medicines and Pharmaceutical Products	867,147	959,595
Monitoring and Evaluation/Research	568,883	502,748
Overheads/Indirect costs	332,888	332,888
Policy and guidelines development and/or update	62,917	90,262
Procurement and Supply Chain Management (PSM)	222,190	219,729
Service delivery	61,790	61,700
	5,088,425	**5,076,817**



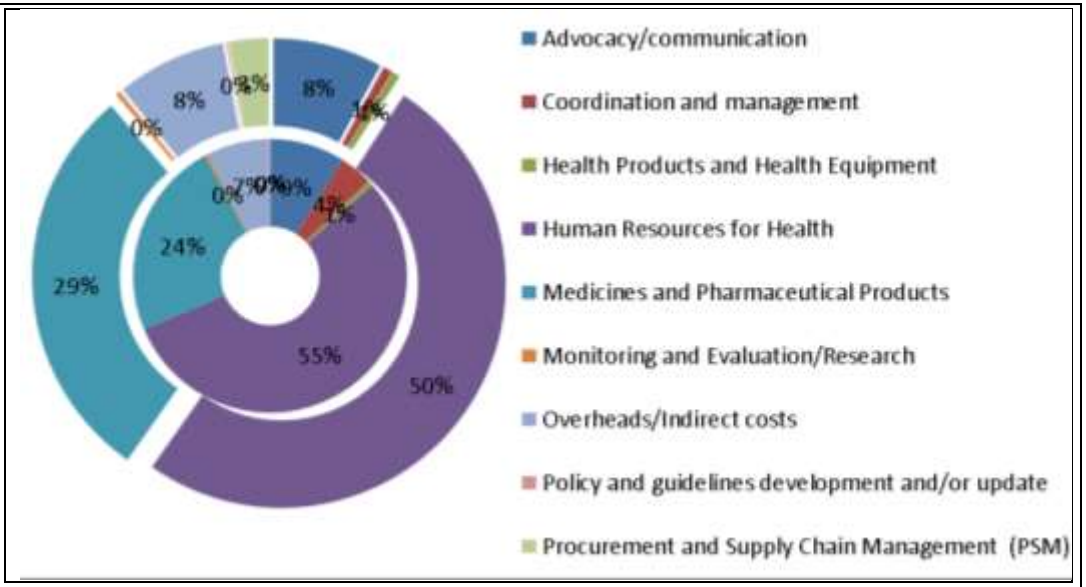
Cameroon	Budget April 2017	Expenditure
Infrastructure and other equipment	2,194,000	2,138,959
Advocacy/communication	964,858	872,028
Coordination and management	154,462	134,462
Human Resources for Health	2,685,072	2,737,683
Monitoring and Evaluation/Research	937,527	804,925
Overheads/Indirect costs	523,320	523,320
Policy and guidelines development and/or update	197,063	183,272
Procurement and Supply Chain Management (PSM)	195,020	183,572
Service delivery	148,000	110,576
	7,999,322	**7,688,797**



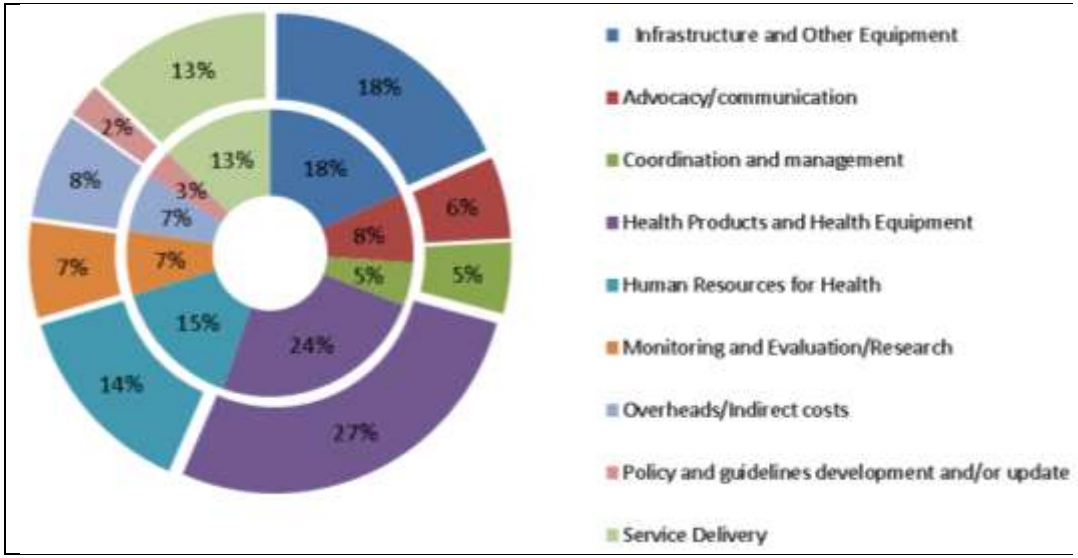
DRC	Budget	Expenditure
Advocacy/communication	1,331,125	1,164,172
Coordination and management	897,243	742,942
Human Resources for Health	2,884,648	2,810,635
Medicines and Pharmaceutical Products	17,574,515	17,574,515
Monitoring and Evaluation/Research	1,442,250	519,352
Overheads/Indirect costs	1,257,559	1,250,941
Policy and guidelines development and/or update	213,125	169,613
Procurement and Supply Chain Management (PSM)	354,230	255,119
	25,954,695	**24,487,289**



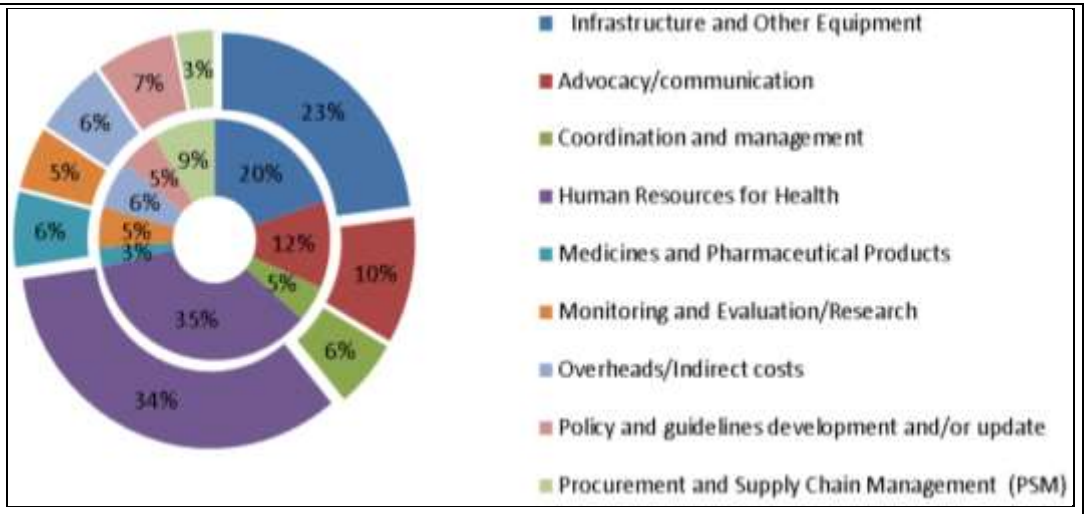
Ethiopia	Budget	Expenditure
Advocacy/communication	2,036,490	1,751,529
Coordination and management	897,495	154,000
Health Products and Health Equipment	143,500	129,326
Human Resources for Health	12,616,704	11,198,265
Medicines and Pharmaceutical Products	5,374,578	6,421,825
Monitoring and Evaluation/Research	82,000	77,858
Overheads/Indirect costs	1,675,359	1,749,752
Policy and guidelines development and/or update	45,083	30,055
Procurement and Supply Chain Management (PSM)	-	628,296
	22,871,210	**22,140,905**



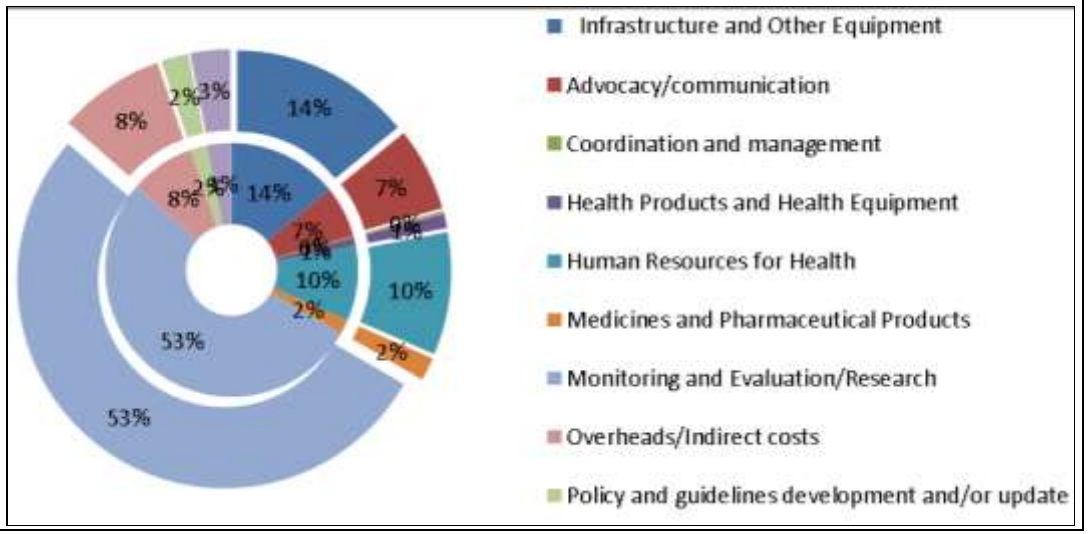
Kenya	Budget	Expenditure
Infrastructure and Other Equipment	2,707,227	2,404,656
Advocacy/communication	1,180,246	753,504
Coordination and management	730,347	656,873
Health Products and Health Equipment	3,634,004	3,584,673
Human Resources for Health	2,217,064	1,816,180
Monitoring and Evaluation/Research	1,084,076	882,431
Overheads/Indirect costs	975,559	975,559
Policy and guidelines development and/or update	488,201	317,862
Service Delivery	1,895,394	1,682,843
	14,912,118	**13,074,582**



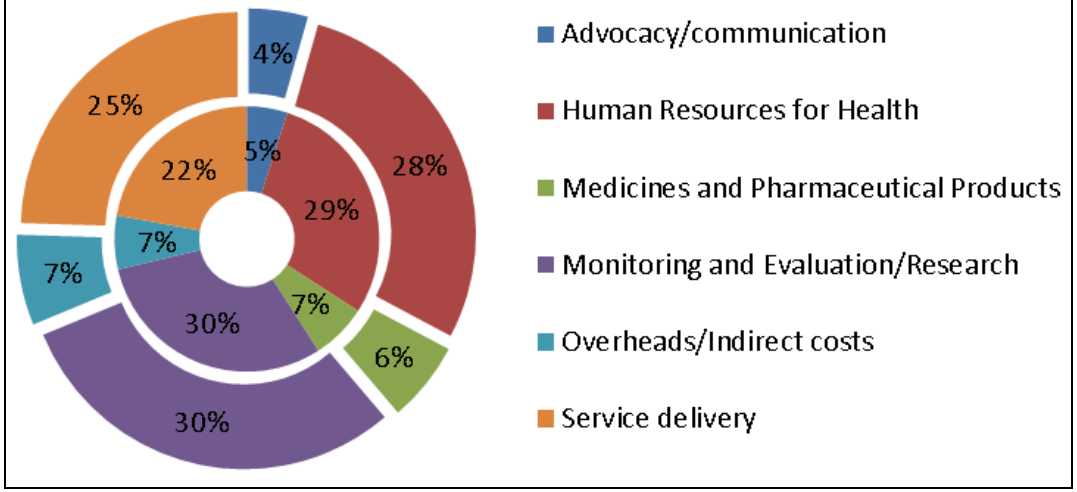
Malawi	Budget	Expenditure
Infrastructure and Other Equipment	2,285,000	2,646,163
Advocacy/communication	1,353,000	1,190,005
Coordination and management	571,000	645,827
Human Resources for Health	4,030,000	3,882,862
Medicines and Pharmaceutical Products	300,000	707,280
Monitoring and Evaluation/Research	631,000	586,107
Overheads/Indirect costs	755,755	707,000
Policy and guidelines development and/or update	620,000	769,434
Procurement and Supply Chain Management (PSM)	1,006,500	367,908
	11,552,255	**11,502,586**



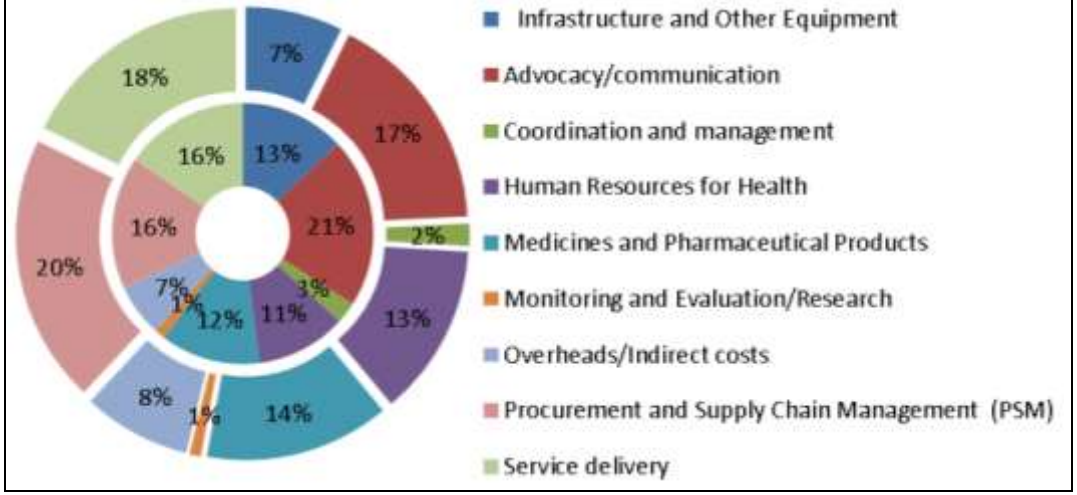
Mali	Budget	Expenditure
Infrastructure and Other Equipment	388,182	388,182
Advocacy/communication	179,069	179,069
Coordination and management	5,127	5,127
Health Products and Health Equipment	30,821	30,821
Human Resources for Health	261,962	261,962
Medicines and Pharmaceutical Products	49,779	49,779
Monitoring and Evaluation/Research	1,456,656	1,456,656
Overheads/Indirect costs	228,972	228,972
Policy and guidelines development and/or update	59,328	59,328
Service delivery	85,354	85,354
	2,745,250	**2,745,250**



Mozambique	Budget	Expenditure
Advocacy/communication	400,000	348,271
Human Resources for Health	2,350,904	2,243,968
Medicines and Pharmaceutical Products	550,000	473,422
Monitoring and Evaluation/Research	2,450,800	2,373,853
Overheads/Indirect costs	527,601	532,295
Service delivery	1,785,449	1,939,093
	8,064,754	**7,910,902**

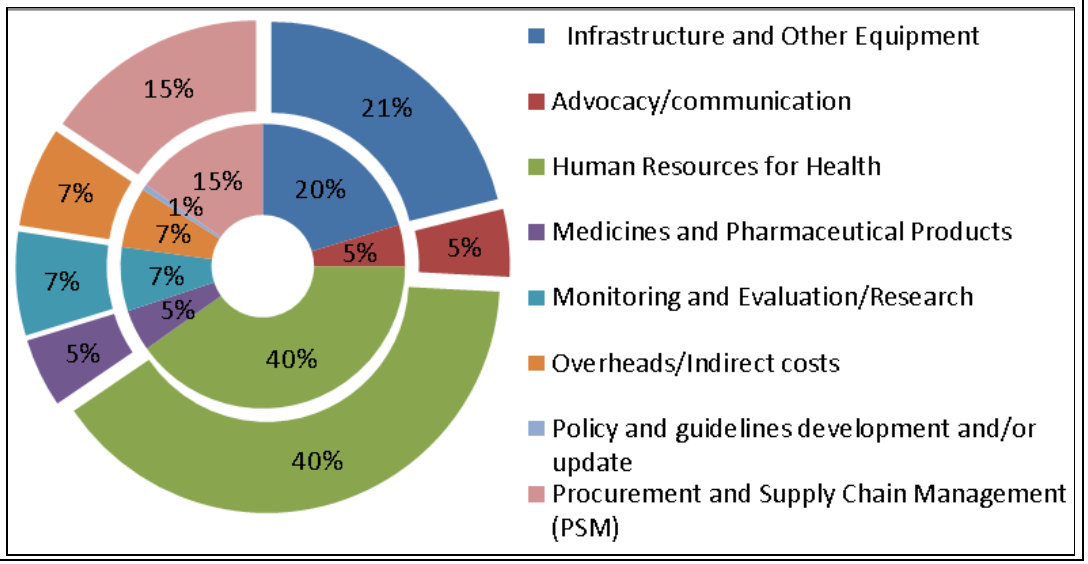


Niger	Budget	Expenditure
Infrastructure and Other Equipment	886,275	401,356
Advocacy/communication	1,432,692	920,784
Coordination and management	180,400	91,399
Human Resources for Health	766,924	710,119
Medicines and Pharmaceutical Products	841,478	762,902
Monitoring and Evaluation/Research	87,990	47,054
Overheads/Indirect costs	445,329	445,329
Procurement and Supply Chain Management (PSM)	1,116,373	1,108,624
Service delivery	1,049,709	965,624
	6,807,170	**5,453,191**

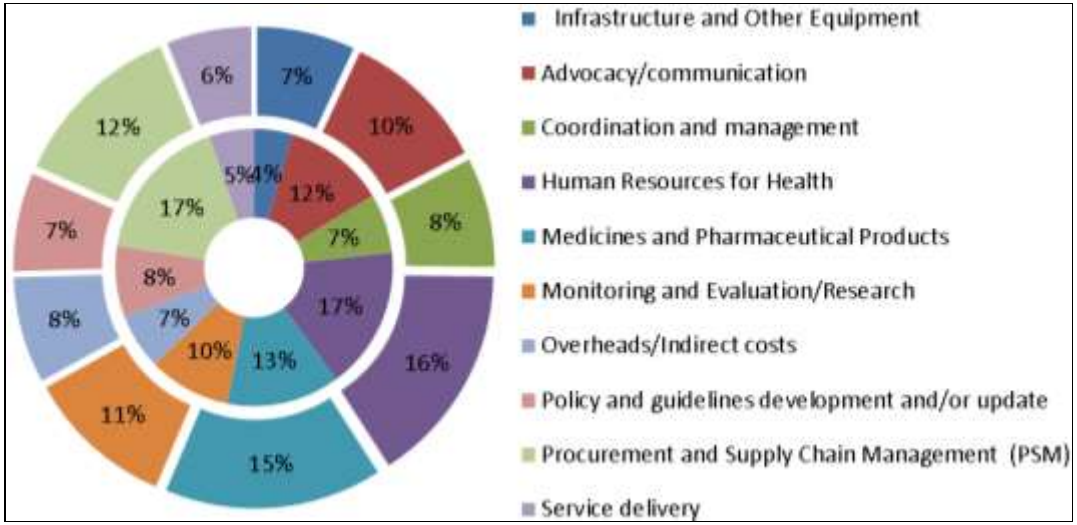


Nigeria	Budget	Expenditure
Advocacy/communication	3,860,000	2,598,851
Coordination and management	65,000	64,701
Human Resources for Health	2,823,761	3,008,992
Monitoring and Evaluation/Research	862,849	860,731
Overheads/Indirect costs	671,584	671,584
Policy and guidelines development and/or update	987,499	1,072,711
Procurement and Supply Chain Management (PSM)	994,955	754,181
Service delivery	15,000,000	15,000,000
	25,265,649	**24,031,752**

Pakistan	Budget	Expenditure
Infrastructure and Other Equipment	1,525,412	1,569,614
Advocacy/communication	354,453	347,250
Human Resources for Health	3,014,826	2,944,188
Medicines and Pharmaceutical Products	354,178	354,919
Monitoring and Evaluation/Research	545,490	533,116
Overheads/Indirect costs	515,588	515,589
Policy and guidelines development and/or update	50,000	
Procurement and Supply Chain Management (PSM)	1,150,200	1,158,200
	7,510,146	**7,422,876**

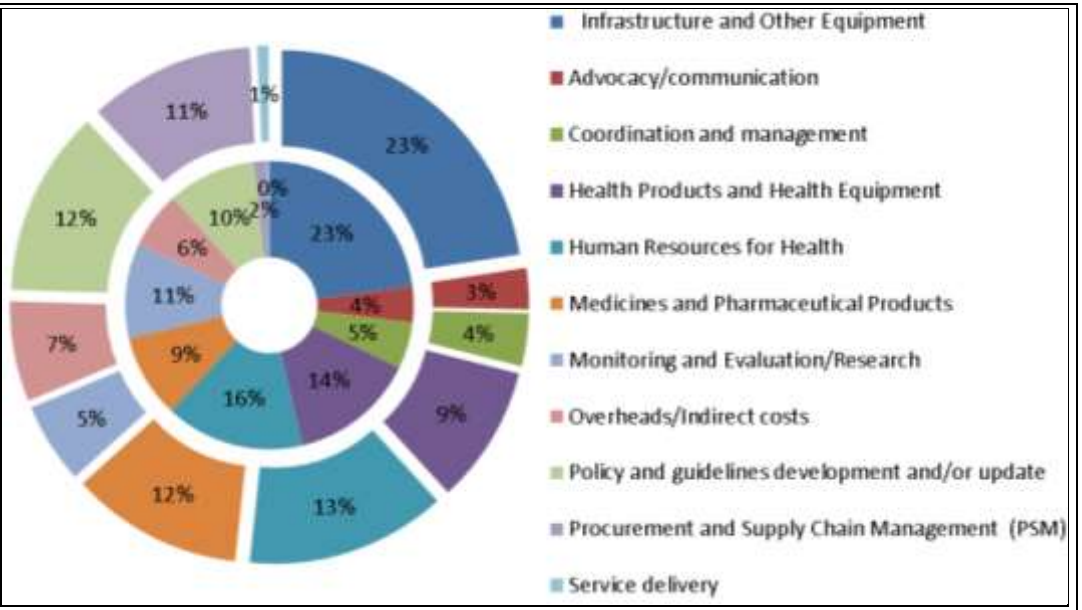


Senegal	Budget	Expenditure
Infrastructure and Other Equipment	465,918	632,881
Advocacy/communication	1,248,356	940,016
Coordination and management	730,588	707,206
Human Resources for Health	1,741,742	1,426,243
Medicines and Pharmaceutical Products	1,385,998	1,404,495
Monitoring and Evaluation/Research	1,003,301	956,813
Overheads/Indirect costs	686,204	686,204
Policy and guidelines development and/or update	872,088	635,513
Procurement and Supply Chain Management (PSM)	1,807,235	1,121,803
Service delivery	547,687	547,687
	10,489,118	**9,058,861**

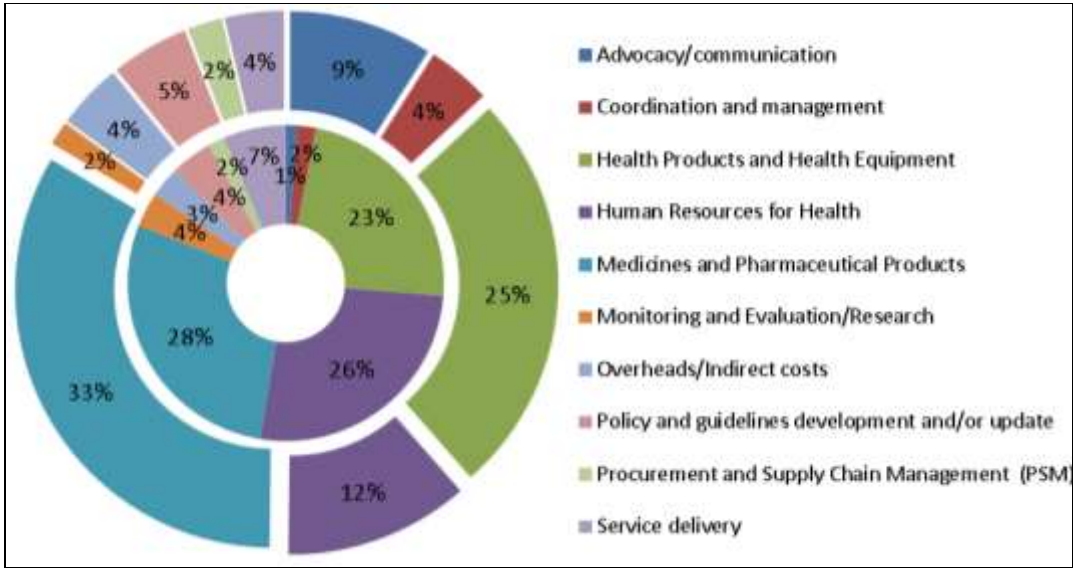


Sierra Leone	Budget	Expenditure
Advocacy/communication	105,000	133,207
Coordination and management	205,311	205,311
Human Resources for Health	2,709,452	2,587,934
Medicines and Pharmaceutical Products	4,997	77,801
Monitoring and Evaluation/Research	736,935	656,453
Overheads/Indirect costs	71,831	81,550
Policy and guidelines development and/or update	635,061	450,134
Procurement and Supply Chain Management (PSM)	75,244	343,690
Service delivery	200,000	200,000

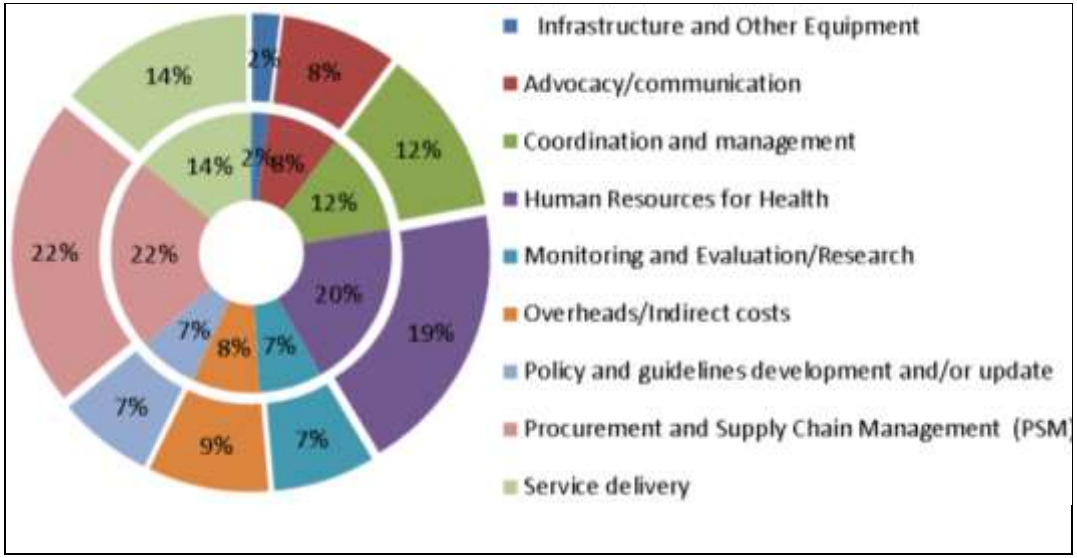
Tanzania-Mainland	Budget	Expenditure
Infrastructure and Other Equipment	3,268,552	3,055,698
Advocacy/communication	566,593	374,684
Coordination and management	746,214	480,963
Health Products and Health Equipment	2,014,366	1,258,769
Human Resources for Health	2,221,316	1,822,402
Medicines and Pharmaceutical Products	1,339,426	1,565,945
Monitoring and Evaluation/Research	1,519,186	737,814
Overheads/Indirect costs	914,259	914,259
Policy and guidelines development and/or update	1,409,217	1,696,301
Procurement and Supply Chain Management (PSM)	207,000	1,509,994
Service delivery	38,462	108,287
	14,244,590	**13,525,117**



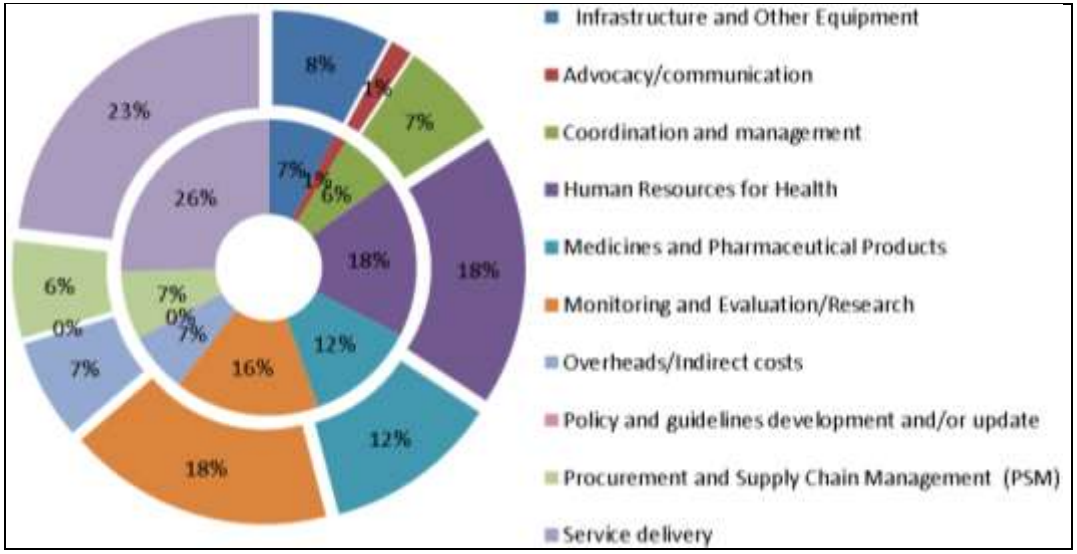
Tanzania-Zanzibar	Budget	Expenditure
Advocacy/communication	18,000	106,887
Coordination and management	31,242	47,665
Health Products and Health Equipment	368,077	302,270
Human Resources for Health	417,697	137,679
Medicines and Pharmaceutical Products	450,000	395,334
Monitoring and Evaluation/Research	56,484	17,991
Overheads/Indirect costs	49,070	49,070
Policy and guidelines development and/or update	68,153	58,056
Procurement and Supply Chain Management (PSM)	26,154	26,154
Service delivery	102,024	43,956



Uganda	Budget	Expenditure
Infrastructure and Other Equipment	163,008	163,008
Advocacy/communication	683,958	683,958
Coordination and management	980,870	980,870
Human Resources for Health	1,605,669	1,605,669
Monitoring and Evaluation/Research	601,164	601,164
Overheads/Indirect costs	636,237	711,603
Policy and guidelines development and/or update	562,207	562,207
Procurement and Supply Chain Management (PSM)	1,831,661	1,831,661
Service delivery	1,154,450	1,154,450
	8,219,224	**8,294,590**



Zambia	Budget	Expenditure
Infrastructure and Other Equipment	514,534	541,615
Advocacy/communication	100,000	100,000
Coordination and management	435,810	456,804
Human Resources for Health	1,226,900	1,242,558
Medicines and Pharmaceutical Products	844,000	798,000
Monitoring and Evaluation/Research	1,112,814	1,216,479
Overheads/Indirect costs	457,944	457,944
Policy and guidelines development and/or update	10,000	-
Procurement and Supply Chain Management (PSM)	516,584	443,584
Service delivery	1,781,414	1,581,582
	7,000,000	**6,838,565**



ANNEX 6 SUMMARY OF REPORTED AVERAGE % ACHIEVEMENT TOWARDS TARGETS

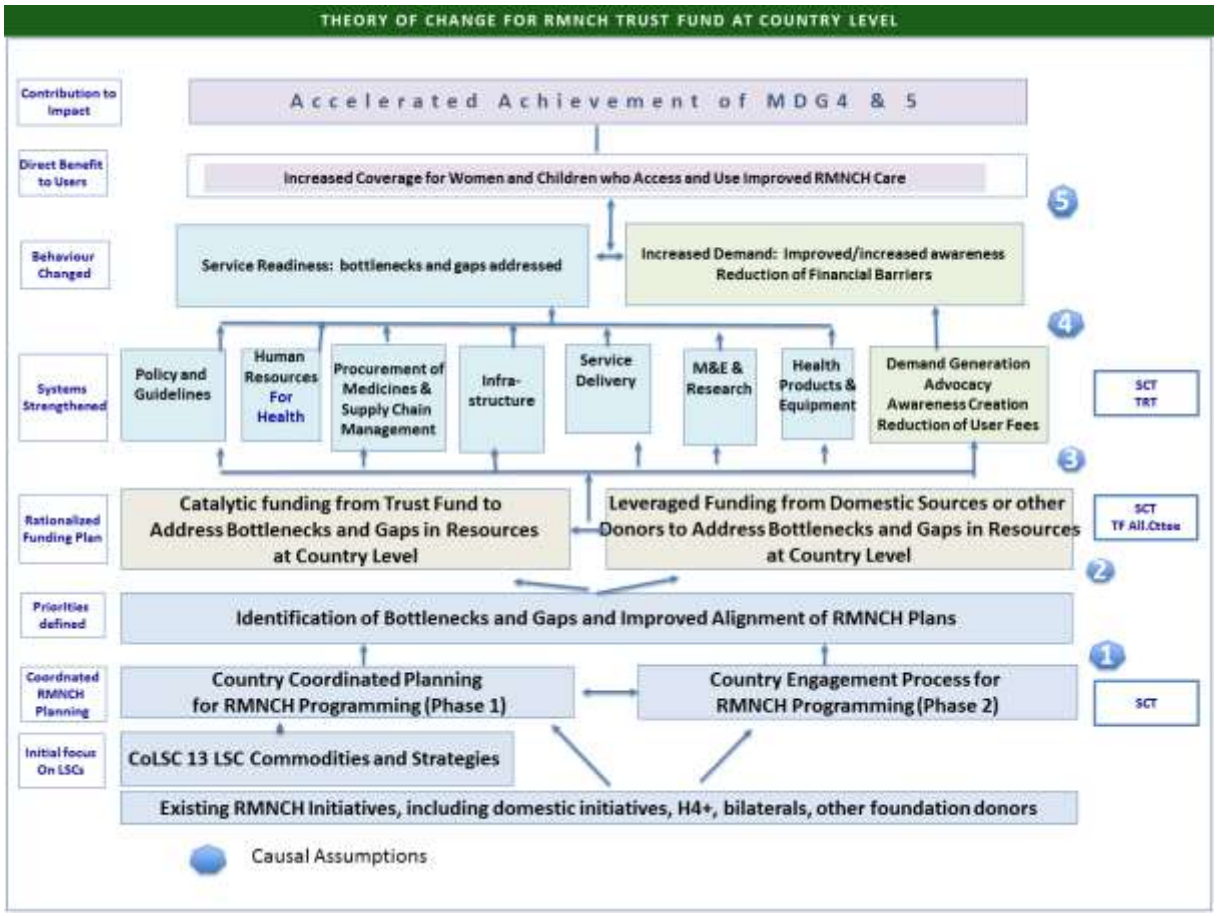
Country and Funding Batch	CEP 1 Average of % Achievement towards Target[6]	UNCoLSC Average % achievement towards Target
Burkina Faso	**93%**	
Overall	**93%**	
Infrastructure and Other Equipment	100%	
Coordination and management	100%	
Health Products and Health Equipment	100%	
Human Resources for Health	87%	
Medicines and Pharmaceutical Products	100%	
Monitoring and Evaluation/Research	91%	
Policy and guidelines development and/or update	82%	
Procurement and Supply Chain Management (PSM)	100%	
Service delivery	100%	
Cameroon	**98%**	
Overall	**98%**	
Infrastructure and Other Equipment	99%	
Advocacy/communication	100%	
Coordination and management	100%	
Human Resources for Health	103%	
Monitoring and Evaluation/Research	92%	
Policy and guidelines development and/or update	100%	
Procurement and Supply Chain Management (PSM)	100%	
Service delivery	80%	
DRC	**82%**	
Overall	**61%**	**91%**
Advocacy/Communication		95%
Coordination and management	54%	100%
Human Resources for Health	84%	80%
Medicines and Pharmaceutical Products	73%	
Monitoring and Evaluation/Research	44%	100%
Policy and guidelines development and/or update	0%	87%
Procurement and Supply Chain Management (PSM)		100%
Service delivery		0%
Ethiopia	**314%**	
Overall	**494%**	**100%**
Advocacy/communication	79%	100%
Coordination and management		
Health Products and Health Equipment		

[6] Source: RMNCH Master Budget Fileas at April 24, 2017, DS Edits

Country and Funding Batch	CEP 1 Average of % Achievement towards Target[6]	UNCoLSC Average % achievement towards Target
Human Resources for Health	766%	
Medicines and Pharmaceutical Products	79%	100%
Monitoring and Evaluation/Research		
Procurement and Supply Chain Management (PSM)		
Policy and guidelines development and/or update		
Malawi	**89%**	
CEP 1	**85%**	**92%**
Infrastructure and Other Equipment	100%	
Advocacy/communication	96%	94%
Coordination and management		100%
Human Resources for Health	67%	84%
Medicines and Pharmaceutical Products		100%
Monitoring and Evaluation/Research	97%	100%
Policy and guidelines development and/or update	100%	97%
Procurement and Supply Chain Management (PSM)	75%	90%
Niger	**78%**	***Ad hoc***
Overall	**80%**	**67%**
Infrastructure and Other Equipment	110%	
Advocacy/communication	94%	0%
Coordination and management	0%	
Human Resources for Health	72%	
Medicines and Pharmaceutical Products	92%	
Monitoring and Evaluation/Research	100%	
Procurement and Supply Chain Management (PSM)	84%	100%
Service Delivery	62%	
Nigeria	**95%**	
CEP 1	**100%**	**95%**
Advocacy/communication		88%
Coordination and management		100%
Human Resources for Health		100%
Monitoring and Evaluation/Research		100%
Policy and guidelines development and/or update		98%
Procurement and Supply Chain Management (PSM)		95%
Service delivery	100%	
Pakistan	**104%**	
CEP 1	**104%**	
Infrastructure and Other Equipment	126%	
Advocacy/communication	100%	
Human Resources for Health	99%	
Medicines and Pharmaceutical Products	100%	
Monitoring and Evaluation/Research	100%	
Policy and guidelines development and/or update		

Country and Funding Batch	CEP 1 Average of % Achievement towards Target[6]	UNCoLSC Average % achievement towards Target
Procurement and Supply Chain Management (PSM)	100%	
Tanzania-Mainland	**94%**	
CEP 1	**92%**	**96%**
Infrastructure and Other Equipment	65%	90%
Advocacy/communication	100%	97%
Coordination and management	100%	100%
Health Products and Health Equipment	91%	
Human Resources for Health	83%	100%
Medicines and Pharmaceutical Products	100%	80%
Monitoring and Evaluation/Research	100%	100%
Policy and guidelines development and/or update	100%	88%
Procurement and Supply Chain Management (PSM)		100%
Service delivery	95%	
Uganda	**78%**	
CEP 1	**79%**	**77%**
Infrastructure and Other Equipment	100%	100%
Advocacy/communication	78%	89%
Coordination and management	96%	88%
Human Resources for Health	85%	79%
Monitoring and Evaluation/Research	55%	63%
Policy and guidelines development and/or update	45%	71%
Procurement and Supply Chain Management (PSM)	100%	90%
Service delivery	59%	0%

ANNEX 7 TESTING CAUSAL ASSUMPTIONS FOR THE RMNCH TRUST FUND THEORY OF CHANGE AT COUNTRY LEVEL



At each level of the ToC, causal assumptions connect to the evaluation matrix, identified by the numbers in Figure 1. (The boxes on the right-hand side relate to anticipated actions on behalf of TF structures: the SCT, the Allocations Committee, the TRT.) Below are the causal assumptions and the evidence that addresses them, and recommendations for future projects. The analysis and triangulation of the evidence helps determine whether the causal assumptions that link the different levels of the ToC hold, and thus helps identify the extent to which the TF made contributions to results in RMNCH.

Level 1 of the ToC implies that countries engaged in a participatory process, with all relevant stakeholders, to review existing RMNCH plans and initiatives, both domestic and international. Through this process they identified and prioritized bottlenecks and gaps aimed at accelerating achievements of MDGs 4 and 5, and prepared a funding proposal and implementation plan to address them.

Level	Assumption	OECD DAC criteria
1	1.2 RMNCH Trust Fund support applied at country level led to: 1.2.1 Engagement of all relevant stakeholders in identifying and prioritizing RMNCH bottlenecks and gaps 1.2.2 The identification of key bottlenecks or gaps in commodities, services and resources relevant to accelerating MDGs 4&5 achievements 1.2.3 A funding request to address them 1.2.4 An implementation plan, including access to technical resources	Relevance

Summary of the evidence:

- *Strong government leadership:* The TF was successful in establishing procedures and providing support to ensure government ownership and leadership of processes to identify and prioritize interventions that expressly addressed bottlenecks and gaps in RMNCH.

- *Inclusive stakeholder engagement:* All relevant stakeholders were involved in the review of plans, and identification of bottlenecks and gaps in both programming and resources. Stakeholder participation broadened in phase 2 with the advent of the CEP.
- *Key bottlenecks and gaps identified:* Countries had one or more harmonized national plans in place, including RMNCH Roadmaps, which were reviewed to identify bottlenecks and gaps. They also drew upon epidemiological and HMIS data, and gaps identified in annual work plans. They used one or more tools to map resources available to support RMNCH activities in their country. In phase 1, this was focused on the 13 LSCs, although not exclusively. In phase 2, the focus was broadened beyond the LSCs.
- *Further prioritization in phase 2:* In phase 2, because the resources were limited, countries made strategic decisions to focus attention on targeted sub-national areas with poor maternal and child morbidity and mortality indicators.
- *Relevant funding proposals and implementation plans* submitted to the TF specifically addressed the prioritized, identified bottlenecks and gaps and were directly relevant to the intention to accelerate MDG 4&5 achievements and provided information on resources available and funding gaps.

Level 1 Summary: The evidence supports the assumptions made in the ToC at level 1. Procedures put in place by the TF led to strong government leadership, inclusive stakeholder engagement, key bottlenecks and gaps being identified, further prioritization in response to resources available, and the submission of relevant funding proposals and implementation plans.

Level 2 of the ToC implies that effective procedures were put in place to respond to the identified bottlenecks and gaps through timely disbursement of TF funds. It also surmises that plans were coordinated to avoid duplication at the national and sub-national levels, and that alternative sources of funds were identified to support activities not funded by the TF.

Level	Assumption	OECD DAC criteria
2	2.1 Processes and procedures were established at global, national and sub-national levels to facilitate effectively the: 2.1.1 Disbursement of TF funds	Effectiveness
	3.1 RMNCH TF partners and other RMNCH partner plans, TA and activities were coordinated to address priority bottlenecks and gaps at the national and sub-national levels without duplication.	Efficiency
	4.3 Alternative sources of funding were identified to address bottlenecks or gaps not funded by the TF	Sustainability

Summary of the evidence:

- *Effective Disbursement of TF funds:* The SCT established flexible and streamlined processes at the global level to facilitate rapid grant disbursements for implementation, including allowing for reprogramming to reflect changing needs. These processes included the requirements for a short proposal, submission of a logframe to outline objectives, funding and expenditures, targets, indicators and progress, and submission of narrative and updated logframe reports. Countries were able to re-programme funds up to $100,000, with SCT approval.
- *No harmonization of procedures across channelling agencies:* Significant differences in procedures of the three UN channelling agencies at the country level led to some delays in disbursement of funds and implementation, and confusion on the part of in-country partners.
- *Internal and external coordination to avoid duplication:* Internal coordination – between the TF and implementing partners and among implementing partners – to address priority bottlenecks and gaps minimized duplication of effort at both national and sub-national levels, thereby maximizing resources, both programmatic and financial. External coordination with other RMNCH partners to avoid duplication occurred in most countries during the initial planning phase.
- *Limited success in identifying alternative resources:* Funding gaps identified in this process far exceeded what the TF could offer, which led to further prioritization to focus on targeted sub-national levels with poor morbidity and mortality indicators. The evidence shows limited success in identifying additional resources to support the gaps and priorities identified.

Level 3: Assumptions at this level imply that priorities were reflected in a coordinated, efficient programme to strengthen health systems and to address demand generation.

Level	Assumption	OECD DAC criteria

3	2.1.2 Rapid programme implementation at the country level given the short duration of the project 2.1.3 Access to global and regional programming support during implementation	Effectiveness
	3.2 The implementation of TF inputs was well sequenced to support improvements in service readiness and demand creation 3.3 RMNCH TF funding and technical support were flexible and responsive to national/sub-national needs	Efficiency

- *Rapid programme implementation:* The previously mentioned flexible and streamlined processes at the global level facilitated rapid grant implementation, including allowing for reprogramming to reflect changing needs.
- *Benefits of centralized procurement through UN system:* Centralized UN commodities and equipment procurement was recognized for the benefits of cost-savings and quality over what could usually be procured in-country.
- *Challenges of centralized procurement through UN system:* lengthy international procurement processes and delays in delivery were not conducive to rapid or timely implementation. It was recognized that sometimes there are in-country importation impediments that affected timely delivery.
- *Global and regional level support during implementation:* TRT direct technical support was not evident in most countries, and, as per the Management Review findings noted in section one, they were not synchronized in order to meet country programme needs. Support was provided from SCT, channelling agencies and in-country experts.
- *Responsiveness to national level and sub-national level needs:* Respondents routinely noted that TF funding and programming support were flexible and responsive to national and sub-national needs. The ability to re-programme funds with minimal delays and procedures and the availability of remaining funds for mini-grants to those engaged with the GFF were much appreciated. In phase 1, engagement of the sub-national level was limited because of the focus on the LSCs which emphasized addressing regulatory and other national systems-level issues. In phase 2, many countries did engage the sub-national level in planning effectively, but respondents in several countries expressed the opinion that more should have been done to engage the sub-national level earlier in the planning stages because their inputs would have contributed to ensuring that interventions and commodities were appropriate for their needs and to more rapid implementation.
- *Sequencing:* Significant efforts were made to ensure that activities were sequenced efficiently. However, sequencing was an issue in some countries due to (a) delays in disbursements previously discussed; (b) delays in procurement (e.g. *DRC and Burkina Faso*); (c) delays in production of guidelines or curricula (e.g. *Nigeria*); (d) late engagement of the sub-national level (e.g. *Tanzani*a); and (e) external factors (e.g. Malawi and the delays caused by the Lancet article on Dexamethasone.)

Level 4: Assumptions at this level address the behaviour change effectively brought about by strengthening systems and addressing demand generation.

Level	Assumption	OECD DAC Criteria
4	2.2 Trust Fund support addressed the three dimensions of sustainable capacity improvement: providers have the *capability, opportunity* and *motivation* to effectively provide quality RMNCH services. 2.3 Trust Fund support addressed the three dimensions of sustainable capacity improvement: users have the *capability, opportunity* and *motivation* to effectively demand and use RMNCH services. 2.1.4 Outputs that can be qualitatively or quantitatively assessed	Effectiveness
	4.1 RMNCH TF activities had sufficient reach, intensity and duration to contribute to and sustain changes in service readiness and demand generation 4.2 Lessons learned, including good and bad practices, have been systematically documented and disseminated at country and regional levels to enhance RMNCH implementation 4.3 RMNCH TF supported interventions have been scaled up with alternative resources and programming support 4.4 An explicit exit strategy was developed to address how supported interventions would be sustained, including both alternative sources of funding and support to interventions aimed at building durability into RMNCH services.	Sustainability

Summary of the evidence:

- *Supporting capability, opportunity and motivation for service providers*: The TF supported high-impact interventions that supported countries to strengthen three dimensions of provider capacity development, including the capabilities, opportunity (i.e. service environment) and motivation of its workforce. This included interventions to improve policy and guidelines, human resources for health (HRH), procurement of medicines, supply chain management, infrastructure, service delivery, M&E and research and health products and equipment. Countries focused on the interventions in proportion to their specific needs. Some focused more on HRH, some on procurement of medicines, some on supply chain management, etc.
- *Supporting capability, opportunity and motivation for women and children*: To a lesser extent, the TF supported interventions that supported countries to increase awareness and generate demand. Emphasis was placed on ensuring that services were available closer to women and children, and to supporting increased awareness of a wide array of "essential family practices." Innovative approaches to encourage voluntary blood donations were also implemented.
- *Outputs that can be qualitatively or quantitatively assessed*. A review of interim and closure reports and TF data was undertaken to determine spending patterns, reported % of achievement towards targets, and completion status. There was a significant amount of funding to be disbursed and expended in a relatively short period of time, driven by the desire to accelerate achievements for MDGs 4 & 5. The evidence does suggest that this multi-country, multi-partner programme was implemented efficiently by the SCT and in-country teams.
- *Reach:* The TF advocated for the identification and implementation of programmatic and geographic priorities. In phase 2, the financial resources available meant that countries needed to target where TF resources could have the most impact, selecting sub-national areas with poor morbidity and mortality indicators.
- *Intensity:* Phase 1, with the focus on the 13 LSCs, provided foundations on which to build in phase 2 and beyond by ensuring improved systems to increase availability and access to LSCs. These foundations will be sustainable in the short to medium term.
- *Duration:* One to two years' programme duration is insufficient to bring about *sustained* changes in service readiness and demand generation. Sustained behavior change of users and providers takes much longer. Anecdotally the evidence suggests significant improvements in foundational elements of programmes that can be built upon. Sustained change will require sustained investment.
- *Documentation:* Because of the short duration of the TF, very little documentation, other than formal reports, was prepared and disseminated. There was little time for evaluation and several respondents noted that this could not be done because they ran out of time.
- *Scale up with Alternative Resources:* There is evidence that some activities will be continued with other resources. However, countries are actively looking for funds to continue this work.
- *No explicit exit strategy:* There was no explicit exit strategy because of the short duration of the TF and the fact that resources were intended to help countries bridge gaps in existing plans.
- *Sustainability:* the lack of exit and sustainability plans, coupled with the short duration of many grants and the lack of follow-on financing, puts the sustainability of the TF achievements at high risk.

Level 5: Assumptions at this level address the overarching question: to what extent did the RMNCH Trust Fund add value.

Level	Assumption	OECD DAC Criteria
5	5.1 RMNCH Trust Fund supported activities were catalytic leading to leveraged funding or a larger programme to accelerate achievement of MDG4&5 5.2 RMNCH TF supported activities are perceived to have contributed to improved access to and use of interventions that would lead to accelerated achievements of MDGs 4&5.	Added Value

Summary of the evidence:

- *What was catalytic?* Stakeholders had the perception that the TF had been "catalytic" but evidence suggests that they often used this term to describe gaps filled, rather than leading to additional resources or a larger programme. For countries accepted into the GFF programme, the TF was catalytic. The coordination and prioritization processes, as well as the ability to use TF funds to develop the investment case has, and will, lead to the identification of significant additional resources. Lessons learned from the TF and the H4+ partnership are believed to create a solid foundation for technically sound interventions and strengthened coordination and alignment in the GFF. There are examples of limited resources being identified to continue one or more activities at the country level, but not the programme as a whole. The TF catalyzed increased attention across all countries on LSCs and on the imperative of accelerating RMNCH achievements.

- *Perceived contribution to improve access and use:* TF support was perceived by stakeholders to have contributed to increased availability and access to products and services. Anecdotal evidence suggests increased access and use, but actual data to support this was not readily available. Landscape synthesis reports demonstrate changes over time and were useful in planning.
- *Ongoing work:* Many programmes were rushing to complete activities by December 2016, and some were still in progress at the time of the evaluation.

In conclusion, the assumptions at level 1 and 2 of the ToC hold, as there is strong evidence that the TF structures and processes facilitated collaborative identification of gaps, prioritization of interventions, and effective and well sequenced implementation of activities. TF supported activities thus clearly contributed to *laying the foundation* for improvements in service readiness and access and utilization by users. The evidence testing the assumptions at level 4 and 5 is less conclusive, and it is thus difficult to assess *the extent to which* the TF contributed to actual behaviour change of service providers and users, i.e. to *sustained* improvements in service availability and quality, and to sustained demand and use of RMNCH services. Given the short duration of the programme in most countries, and the strong focus on being gap-filling and catalytic, the evaluation team found that TF cannot has not yet had any sustained effects at level 4 and 5 of the ToC.

ANNEX 8 TERMS OF REFERENCE

TOR - Global - UNICEF RMNCH Fund