UNICEF Tanzania
Saving mothers’ and children’s lives through innovative, sustainable, and comprehensive reproductive, mother, child and adolescent health services, 2015-2019

Endline Evaluation Report

04 August 2020
Final Report
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<tr>
<td>AFRH</td>
<td>Adolescent-Friendly Reproductive Health</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<td>AVD</td>
<td>Assisted Vacuum Delivery</td>
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<td>BBC</td>
<td>British Broadcasting Corporation</td>
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<td>BEmONC</td>
<td>Basic Emergency Obstetric and Newborn Care</td>
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<td>BPP</td>
<td>Birth Preparedness Plan</td>
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<td>CEM</td>
<td>Coarsen Exact Matching</td>
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<td>CEmONC</td>
<td>Comprehensive Emergency Obstetric and Newborn Care</td>
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<td>CHMT</td>
<td>Council Health Management Team</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>C-section</td>
<td>Caesarean Section</td>
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<td>DHIS</td>
<td>District Health Information System</td>
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<td>DHS</td>
<td>Demographic Health Survey</td>
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<td>DMO</td>
<td>District Medical Officer</td>
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<td>EA</td>
<td>Enumeration Area</td>
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<td>EmONC</td>
<td>Emergency Obstetric and Newborn Care</td>
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<td>FANC</td>
<td>Focused Antenatal Care</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>GoT</td>
<td>Government of Tanzania</td>
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<td>HCFs</td>
<td>Health Care Workers</td>
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<td>HH</td>
<td>Household</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HMT</td>
<td>Health Management Team</td>
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<td>HRH</td>
<td>Human Resources for Health</td>
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<td>IDI</td>
<td>Individual Depth Interview</td>
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<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>IP</td>
<td>Implementing Partner</td>
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<td>IPC</td>
<td>Interpersonal Communication</td>
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<td>IPT</td>
<td>Intermittent Preventive Treatment</td>
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<td>KCMUCo</td>
<td>Kilimanjaro Christian Medical University College</td>
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<td>KII</td>
<td>Key Informant Interview</td>
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<tr>
<td>KMC</td>
<td>Kangaroo Mother Care</td>
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<td>KOICA</td>
<td>Korea International Cooperation Agency</td>
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<td>LSTM</td>
<td>Liverpool School of Tropical Medicine</td>
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<td>MIS</td>
<td>Malaria Indicator Survey</td>
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<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
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<td>MnM</td>
<td>Mama na Mwana</td>
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<tr>
<td>MOHCDGEC</td>
<td>Ministry of Health, Community Development, Gender, Elderly and Children</td>
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<td>MoHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<td>MPDR</td>
<td>Maternal and Perinatal Death Review</td>
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<td>MPDSR</td>
<td>Maternal and Perinatal Death Surveillance and Review</td>
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<tr>
<td>MVA</td>
<td>Manual Vacuum Aspiration</td>
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<tr>
<td>NBS</td>
<td>National Bureau of Statistics</td>
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<td>NIMR</td>
<td>National Institute of Medical Research</td>
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<td>PHC</td>
<td>Population and Household Census</td>
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PMTCT  Prevention of Mother to Child Transmission of HIV
PNC    Postnatal Care
PORALG President's Office, Regional Administration and Local Government
PPC    Prenatal and Postpartum Care
PSU    Primary Sampling Unit
QIT    Quality Improvement Team
RAS    Regional Administrative Secretary
RCH    Reproductive Child Health
RHMT   Regional Health Management Team
RMNCAH Reproductive, Maternal, Newborn, Child and Adolescent Health
RMNCH  Reproductive, Maternal, Newborn and Child Health
RMOs   Regional Medical Officers
SBCC   Social Behaviour Change Communication
SDGs   Sustainable Development Goals
SIMAVI Support for Medical Affairs for Indonesians
SMS    Short Message Service
SOP    Standard Operating Procedure
SO     Strategic Objectives
STIs   Sexually Transmitted Infections
TANESCO Tanzania Electric Supply Company
TARURA Tanzania Rural and Urban Roads Agency
TBE    Theory-Based Evaluation
TDHS   Tanzania Demographic and Health Survey
ToC    Theory of Change
ToR    Terms of Reference
ToT    Training of Trainers
TTCIH-Ifakara Tanzanian Training Center for International Health-Ifakara
UMATI  Chama cha Uzazi na Malezi Bora Tanzania
UN     United Nations
UNICEF United Nations Children's Fund
WCBA   Women of Child-Bearing Age
WHO    World Health Organization
WIT    Work Improvement Team
Executive summary

The Government of Tanzania (GoT) has prioritized the reduction of maternal and newborn deaths and stillbirths in line with global efforts as advocated by Sustainable Development Goal 3 (SDG 3). The government has developed and implemented the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania (i.e., One Plan (2008-2015), Sharpened One Plan (2014-2015) and One Plan II (2016-2020). It is also working closely with development partners like UNICEF to address the challenges in accessing quality health care, with a specific focus on reproductive, maternal, newborn, child, and adolescent health (RMNCAH).

Tanzania has seen a decline in the child mortality rate since 1999, with the number of infant deaths reducing from 99 to 43 deaths per 1000 live births and the under-five mortality rate dropping from 147 deaths to 67 deaths per 1000 live births. Even with these reductions in fatalities, there is still concern about the high rates of death among mothers and newborns in Tanzania, with a maternal mortality ratio of 556 per 100,000 live births as of 2015 and neonatal mortality at 25 per 1,000 live births (Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16).

Several factors contribute to the high maternal mortality ratio, most of which are preventable or treatable. In Tanzania, maternal deaths occur because almost half the births are home births, which occur in the absence of skilled birth attendants and often under unhygienic conditions — resulting in delays in receiving proper health care for any life-threatening condition that may occur. These delays occur in three different phases: delay in making the decision at home to seek care, delay in reaching the health facility, and delay in receiving care at the health facility. The most affected are women in the rural areas who come from the most impoverished households, and those with less education.

UNICEF Tanzania, with funding from the Korea International Cooperation Agency (KOICA) and in partnership with the GoT, designed and implemented the Saving mothers’ and children's lives through innovative, sustainable, and comprehensive reproductive, maternal, child, adolescent health services project in Mbeya and Songwe regions from March 2015 – June 2019.

The main objective of the project was to contribute to the reduction of maternal and newborn deaths from obstetric complications in Mbeya and Songwe regions, with the aim, in the long run, to contribute to the reduction of maternal, neonatal and child mortality and improve the health of women, children and adolescent girls in Tanzania. It aimed to achieve this by improving the availability and readiness of quality Micah services, increasing the utilization of RMNCAH services, and increasing the community awareness and demand for quality RMNCAH services.

Kantar was commissioned in August 2019 to undertake the endline evaluation of the Saving mothers’ and children's lives through innovative, sustainable, and comprehensive reproductive, maternal, child, adolescent health services project (referred to as UNICEF/KOICA project henceforth). This report presents the final endline evaluation results of the project on the key outcomes of interest.

Evaluation approach

The purpose of the evaluation was to generate substantive evidence and lessons learned on the relevance, effectiveness, efficiency, sustainability, gender, and equity focus of the “Saving mothers’ and children’s lives through innovative, sustainable and comprehensive reproductive, mother, child and adolescent health services” project.

Specifically, the objectives of the evaluation were three-fold:

(i) Determine the relevance, effectiveness, efficiency, sustainability, gender and equity focus of the project;
(ii) Assess the integration of critical organizational principles and approaches, namely equity and gender in project planning, implementation and monitoring; and

(iii) Document good practice, lessons learned, and provide actionable recommendations for improvements of future anticipated project design and advocacy for scaling up.

The primary audience of this evaluation includes the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC), the President’s Office, Regional Administration and Local Government (PORALG), UNICEF Tanzania Country Office, and KOICA.

The evaluation does not assess impact questions since the baseline assessment did not cover impact level indicators, and due to delays in the start-up of the implementation of the project, it is too early to provide an accurate picture of the impacts of the project.

The evaluation employed a Theory-Based Evaluation (TBE) approach, which used the project’s theory of change (ToC) to conclude whether and how the interventions contributed to the outcomes of the project. The TBE approach allowed us to examine the relationships between the project activities, outputs, and outcomes and further the mechanisms of change, as well as the assumptions, risks, and contexts that support or hinder the theory from being manifested. We utilized mixed methods that included quantitative, qualitative, and secondary data sources (e.g., project monitoring data and policy documents) to address each of the evaluation questions.

Key findings

1. Relevance

The evaluation found that the project design results and implementation strategies were relevant to the national and sub-national contexts, strategies, policies, and programs. From the perspective of the country context analysis, the project was established at the time when many RMNCAH indicators in Tanzania, in general, and in Mbeya and Songwe regions, in particular, were performing poorly. Maternal and neonatal mortality were high, quality of RMNCAH services was compromised with numerous health system issues, utilization of health services was comparatively low, and coverage and availability of Adolescent Friendly Reproductive Health (AFRH) services were low. Also, the project objectives, planned outputs and outcomes were all aligned within the policy framework and GoT’s commitments as described in Tanzania’s Vision 2025, the second Five Year Development Plan, the Tanzania Health Policy (2007), as well as the New Health Policy Draft (2020), Health Sector Strategic Plan IV, the RMNCAH Road Map (2016 - 2020) and the National eHealth Strategy (2013).

The relevance of the project was also seen from the design aspect. The design employed a set of strategic plans that the country, with its development and implementing partners, had decided to pursue. The decision to implement RMNCAH holistically was in alignment with both the GoT guidelines and the World Health Organization (WHO) recommendations. The project design and implementation were widely accepted and praised by a wide range of stakeholders at the national and sub-national level, as well as by the targeted primary beneficiaries (i.e., pregnant women, newborn children, children under-five and adolescent girls and boys (10-19 years) in the 12 districts across Mbeya and Songwe region.

2. Effectiveness

The project has made significant strides in improving the availability and readiness of the target health facilities to provide RMNCAH services in both Mbeya and Songwe. This is demonstrated through the increased capability of the strategic health facilities to provide the seven Basic Emergency Obstetric and Newborn Care (BEmONC) and nine Comprehensive Emergency Obstetric and Newborn Care (CEmONC) signal functions, proper use of partographs, and the availability of AFRH services. The improvements observed are a contribution of the refurbishment and renovation, procurement, and distribution of equipment, as well as training of health care workers. Over the course of the project lifetime, the number of strategic
health facilities providing all seven BEmONC signal functions increased from zero at baseline to 18 health facilities at endline. Among the remaining 12 facilities that were not providing all seven BEmONC signals, the most common functions that were not being performed at endline include Manual Vacuum Aspiration (MVA) (nine facilities were not performing this function), Assisted Vacuum Delivery (AVD) (eight facilities were not performing this function) and Manual Removal of the Placenta (MRP) (four facilities were not performing this function). The main reasons cited by the facilities for not being able to perform these signal functions include the lack of trained personnel or functional equipment. While the project trained health care workers (HCWs) across all 30 health facilities on all BEmONC signal functions, staff transfer, and turnovers are likely contributing factors to some facilities reporting the lack of trained staff to take on these functions.

The project targeted seven health facilities to be upgraded to CEmONC levels, which includes the capacity to undertake all nine CEmONC signal functions. By the end of the project, only three out of the seven targeted health facilities could provide all nine signal functions. Five out of the seven facilities were capable of providing Caesarean section (C-sections) relative to only one facility at baseline. Similarly, six out of the seven facilities could provide blood transfusions at endline, which is a major improvement from baseline, when only one facility had that capability. Across the nine CEmONC signal functions, two out of the seven facilities did not perform AVD and one facility could not perform MVA, thus resulting in only three out of the seven facilities having the capacity to perform all nine signal functions by endline.

Although the project was not able to meet its intended target for all 30 health facilities providing all seven BEmONC signal functions, and seven target health facilities providing all nine CEmONC signal functions as part of their routine functions, by the end of the project, it was successful in increasing the capacity of the targeted health facilities, overall.

In addition, the project contributed to improvement in the quality and readiness of RMNCAH services in a number of other areas. As part of the project, AFRH services were established and HCWs were trained on providing the services across the 30 strategic health facilities, services that did not exist at baseline. All health facilities continue to use partographs, filling them out properly (how the forms were being filled out showed marked improvement over the course of the project). Other areas include upskilling HCWs through training and providing essential equipment for improvements in antenatal care (ANC), delivery, and postnatal care (PNC) services, and established kangaroo mother care (KMC) services through skill-based training of HCWs and supportive clinical mentorship across select district hospitals and health facilities.

The project also established quality improvement teams across all health facilities, with the exception of one facility, and strengthened supportive supervisions through technical support via training and accompanying supervisors to quarterly visits. The project also supported the finalization of Tanzania’s RMNCAH Integrated Supportive Supervision guidelines, which will contribute not only to the improvement in the quality of care and RMNCAH service provider accountability in the target regions and districts, but in the country as a whole. Alongside the supportive supervision, the project supported all 30 strategic health facilities to conduct monthly maternal and perinatal death surveillance reviews (MPDSR) and provided technical and financial support in the development of MPDSR guidelines and tools, printing and dissemination. Lastly, the project contributed to strengthening the existing referral system in Mbeya and Songwe regions by procuring and strategically distributing 11 ambulances across the target districts.

Achievement of increased utilization of RMNCAH services are positive, with the project meeting the majority of its targets. The improvements in the availability and readiness of RMNCAH services have contributed to changes in the perceptions and attitudes of women (15-49 years) seeking care within Mbeya and Songwe regions about the targeted health facilities. Women reported noticing improvements in services over the course of the project ranging from better equipment, less waiting times, and friendlier staff, among others.
The project has seen statistically significant improvements from baseline to endline in the number of pregnant women attending four or more ANC visits (68% to 86%, respectively), receiving IPT during their ANC visits (70% to 91%, respectively), and an increase in the number of live births attended by skilled personnel for the most recent birth (83% to 95%, respectively). Targets for pregnant women attending four or more ANC visits and receiving IPT have been met. Similarly, the project also contributed to the increase in the number of mothers initiating breastfeeding within an hour of birth (58% to 80%, respectively) and very small improvements in those women seeking PNC within 48 hours of giving birth (16% to 19%, respectively). These changes are not statistically significant. The number of mothers who attended their first ANC within 12 weeks of their pregnancy was at 56% at endline.

Awareness levels among women, their husbands, and their fathers and mothers-in-law on the value and importance of women visiting health facilities for ANC, delivery, and PNC were over 85% at baseline and have only seen an increase over the course of the project. Some of the project’s contributions to raising awareness and demand for RMNCAH services include the community and facility dialogues which have helped to encourage husbands and women to seek ANC services as early as possible; prepare for transportation to the health facility for women in labor through birth preparedness plans; the counseling women received at the health facility during their ANC visits around the danger signs they should look for during their pregnancy, delivery, and post-delivery, as a result of the training that HCWs received; and the information shared via the Mama na Mwana (MnM) service and information, education, communication materials around their pregnancy, but also the opportunity to provide feedback on the services received via the MnM service, and through the community scorecards as part of the community-facility dialogues. The improvements in the readiness and availability of RMNCAH services have also contributed to women more easily accessing the services they require closer to their homes, reducing the transport costs necessary to seek specific services far outside of their communities.

3. Efficiency

Managerial and coordination efficiency was highly observed at the national and sub-national government levels. The evaluation findings showed the project successfully integrated its activities with the sub-national and council level programs of work, drew joint plans, exercised transparency in budget allocations for various interventions, and jointly conducted supportive supervision and monitoring of the project activities. According to the project progress reports, compliance with the timeline was very high, and the project made significant progress to meet various set targets, with the exception of some delays at the onset of the project. Efficiency in managerial and coordination aspects of the project was also fairly found with other maternal and newborn child health (MNCH) partners as well as at the project level.

4. Gender and equity

The project design and implementation contributed to reducing inequalities and gender disparities by targeting and reaching many of the most vulnerable women and adolescent girls in the Mbeya and Songwe regions through its multi-pronged implementation approach. To address inequitable access to RMNCAH services across the two regions the project improved the quality and readiness of RMNCAH services in 30 strategically located health facilities that provide access to health care to areas that are peripheral and remote across the 12 districts. The project established and supported AFRH services across all of the strategic health facilities, which has contributed to increased access and the overall experience for adolescent mothers by shortening their waiting times, customizing their ANC services, and increasing privacy.

The project also contributed to increased health awareness and practices at both the health facility and community level. At the health facility through trained HCWs the project ensured that women and adolescents received the appropriate counseling during the ANC visits, delivery and PNC. HCWs also encouraged the participation of male partners as this was a key component of the training and community level awareness initiatives advocated by the project. At the community level, the project raised awareness to
increase demand and access to RMNCAH services through community shows and community facility dialogues. The content of these community level interventions encouraged male participation to encourage access and utilization of quality RMNCAH services for their partners.

One key drawback in the project design was that it did not factor in interventions specific to women and adolescent girls that face disabilities. The project would have benefited from incorporating HCW training and community outreach to seek and provide services to pregnant women and adolescents facing disabilities to strengthen the equity and gender approach to reach the most vulnerable populations.

5. Sustainability

The project has been successful in establishing processes and systems that are likely to support the continued implementation of the project. These include:

- Influencing policy through technically and financially supporting the development and rollout of MNCH guidelines, namely "National Guidelines for Neonatal Care and Establishment of Neonatal Care Unit," Integrated RMNCAH Supportive Supervision” and the “Maternal and Perinatal Death Surveillance and Response Guidelines.”
- Capacity building of health managers, mentors and service providers to provide quality RMNCAH services and continued supportive supervision and mentorship in the target districts and wider country.
- Changing attitudes and perceptions among communities on improved utilization of RMNCAH services through the MnM service, which is under discussion to be integrated and adopted by the national government.
- Development of reference materials such as job aids that remain as living resources for both service providers and regional and district councils to reproduce and utilize for future use.

Some of the key enabling factors for sustainability include the highly integrative and participatory approach taken by the project. This has created a sense of ownership among stakeholders at the sub-national, council and community levels, project responsiveness to the real issues and priorities of the locals, as well as the availability of capable health managers and service providers with enabled competence to implement the same quality of service routinely. One key constraining factor for sustainability is the availability of government funds to continue the implementation of some key project activities such as routine supportive supervision and MPDSR meetings now that the project has ended.

Recommendations

1. UNICEF should, as soon as possible, share learnings and good practices emanating from the experience of ‘strategic selection of health facilities for improving quality and readiness of RMNCAH services’ to the MOHCDGEC and PORALG to inform national scale-up strategies and current government directives around upgrading of selected health centers to provide CEmONC services. This can be done by developing policy briefs or short reports that describe the strategy and processes involved as well as by conducting dissemination meetings with the two ministries.

2. The offices of Regional Administrative Secretary (RAS) for Mbeya and Songwe, which are responsible for overseeing all sectors in the regional level, should, as soon as possible, bring together sectors responsible for energy (through Tanzania Electric Supply Company (TANESCO)) and road construction (through Tanzania Rural and Urban Roads Agency (TARURA)) to address and prioritize issues of power availability and road improvements in catchment areas of the "strategically selected health facilities" in order to optimize and complementing the project outcomes as well as sustaining the project achievements. UNICEF can support this effort by sharing this learning with RAS office during dissemination sessions with sub-national levels and through a concise brief.
3. UNICEF should plan to disseminate the findings of the project outcomes to key stakeholders at the national and sub-national government and the wider MNCH stakeholders involved in the project. The dissemination content should be targeted at specific types and levels of stakeholders. This will be a motivation for the regions, councils, health facilities, and community to sustain the good outcomes from the project.

4. The mHealth section at MOHCDGEC should in the near future, build on the success of MnM and integrate it within the National "Wazazi Nipendeni" program. Specifically, the use of the MnM service in improving quality of care and accountability at the health facility through feedback on services received and reminders on PNC/ANC appointments. This can be achieved through a series of discussions engaging the innovation team from UNICEF on operability and synergy of the two systems.

5. The Regional Administrative and Local Government (Regional Health Management Team (RHMT) and County Health Management Team (CHMT)), needs to develop and implement human resource capacity development plan aimed at sustaining the trainings and skills developed by the UNICEF/KOICA project through the use of trainers and mentors at the national and sub-national level. This should be implemented as soon as preferably by integrating the plan within the next planning cycle. The plan should be practical and sustainable by allowing for skill transfer to new staff and also upskilling existing staff with refresher trainings based on needs identified through the supportive supervision visits and ensure they are tied to BEmONC and CEmONC signal functions.

6. PORALG should support the RHMT and CHMT by allowing regions and councils to allocate sufficient funding for the human resource capacity development plan and capacity building activities. This can be considered in the forthcoming planning cycle.

7. The Reproductive and Child Health Section at PORALG, needs to ensure sufficient budget are provided to regions to conduct regular supportive supervision of the strategic health facilities to (i) assess availability and functionality of equipment and buildings supplied by the UNICEF/KOICA project; (ii) identify any skill gaps and address through mentorships and trainings and (iii) ensure Maternal and Perinatal Death Review (MPDR) are being conducted regularly by health facilities in accordance to the government guidelines.
1. Introduction

1.1 Context

Sustainable Development Goal 3 (SDG 3) focuses on “ensuring healthy lives and promoting well-being for all at all ages,” through the reduction of maternal mortality and ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs by 2030. There is considerable progress globally and by individual countries in reducing maternal mortality to less than 70 per 100,000 live births and neonatal mortality to less than 12 per 1,000 live births. Tanzania, like the other countries, is also aiming to attain SDG 3 by 2030.

To this effect, the Government of Tanzania (GoT) has prioritized the reduction of maternal and newborn deaths and stillbirths. It has developed and implemented the National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania — One Plan (2008-2015), Sharpened One Plan (2014-2015) and One Plan II (2016-2020). The GoT is also working closely with development partners like UNICEF and others to address the challenges in accessing quality health care, with a specific focus on reproductive, maternal, newborn, child, and adolescent health (RMNCAH).

Child mortality rates in Tanzania have seen a decline since 1999, with the number of infant deaths decreasing from 99 to 43 deaths per 1,000 live births, and the under-five mortality rate dropping from 147 deaths to 67 deaths per 1,000 live births. Even with these reductions in fatalities, there is still concern about the high rates of death among mothers and newborns in Tanzania, with a maternal mortality ratio of 556 per 100,000 live births for the period 2006-2015 and neonatal mortality of 25 per 1,000 live births (Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015-16).

Several factors contribute to the high maternal mortality ratio, most of which are preventable or treatable. In Tanzania, maternal deaths occur because almost half of the births are home births, which occur in the absence of skilled birth attendants and often under unhygienic conditions, resulting in delays in receiving proper health care for any life-threatening condition that may arise. These delays occur in three different phases: delay in making the decision at home to seek care, delay in reaching the health facility, and delay in receiving care at the health facility. Several reasons contribute to the first two types of delays including unequal power relations in the home and discriminatory cultural practices against women; women lack the financial resources and decision-making power regarding their health during pregnancy and after birth; maternal health-seeking behaviors; lack of male support; ignorance on danger signs/labor; workload on women during pregnancy; and community perceptions that maternal health is a women’s issue.

The health of the mother during pregnancy plays a vital role in the neonatal period. The quality of health services and the care given before, during, and within the first month after childbirth is equally important. Some of the reasons for the lack of, or poor quality of care is a result of few skilled birth attendants, lack of essential lifesaving equipment and supplies, and poor infection prevention and control practices.

In Tanzania, pregnant adolescents face unique risks due to the high vulnerabilities faced during this stage of life, social and cultural stigma associated with teenage pregnancy, and limited access to financial resources and Adolescent Friendly Reproductive Health (AFRH) services. The behavior of health care workers (HCWs) towards pregnant adolescents’ effects when they initiate and how long they continue antenatal care (ANC). Family and community influences, including parental attitudes, also delay their initiation of ANC. Adolescent girls and specific groups of women who are particularly marginalized include HIV positive women and girls, those that are affected by disabilities, and victims of harmful traditional practices, including early child marriage and female genital cutting/mutilation.

UNICEF has been actively involved in initiatives aimed at improving maternal, newborn, child, and adolescent health in Tanzania. UNICEF Tanzania, with funding from the Korea International Cooperation
Agency (KOICA) and in partnership with the Government of Tanzania, implemented the “Saving mothers’ and children's lives through innovative, sustainable, and comprehensive reproductive, maternal, child, adolescent health service” project in Mbeya and Songwe regions from March 2015 – June 2019 (subsequently referred to as UNICEF/KOICA project throughout this report).

Kantar was commissioned in August 2019, to undertake the endline evaluation of the UNICEF/KOICA project. This report presents the final endline evaluation of the project, as outlined in the evaluation ToR.¹

1.2 About the project

The main objective of the UNICEF/KOICA project was to contribute to the reduction of maternal and newborn deaths from obstetric complications in Mbeya and Songwe regions. It aimed to achieve this by improving the availability and readiness of quality RMNCAH services, increasing the utilization and community awareness and demand for quality RMNCAH services in Mbeya and Songwe regions.

Several factors contribute to the poor availability, quality, and utilization of RMNCAH services, such as poor road infrastructure, inequitable distribution of health facilities, and poorly managed and maintained health facilities. A number of social, cultural, and economic factors also contribute to poor utilization of services (i.e., the inability to pay the fees associated with RMNCAH services, lack of knowledge of the danger signs in pregnancy, and the lack of understanding of the importance of optimal maternal nutrition, as well as infant and young child feeding practices. HCW attitudes about patient privacy and confidentiality also influence the use of some types of RMNCAH services by pregnant women and adolescent girls.²

To address the causes and contributors to the high maternal and newborn mortality rates in Mbeya and Songwe regions,³ the project design applied the “three delays” model by Thaddeus and Maine⁴ to conceptualize the causes/contributors to availability, quality, demand and utilization of RMNCAH services and inform the design of the interventions to address these barriers. Table 1 outlines the barriers the project targeted under each delay.

Table 1: Three delays model – causes or contributors to maternal and newborn mortality⁵

<table>
<thead>
<tr>
<th>Phase I: Delay in deciding to seek care</th>
<th>Phase II: Delay in identifying and reaching medical facilities</th>
<th>Phase III: Delay in receiving adequate and appropriate medical care at the facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Economic factors: Costs associated with seeking and receiving care are expensive</td>
<td>Inequitable access to emergency obstetric and newborn care (EmONC) services in Mbeya and Songwe regions</td>
<td>Inadequate or insufficient infrastructure and equipment for maternal, newborn, child health (MNCH) and AFRH services</td>
</tr>
<tr>
<td>Socio/cultural factors: restriction in women’s decision-making abilities, traditional norms of delivering at home with traditional birth attendants</td>
<td>Insufficient availability of transport for emergency referrals and lack of affordable public transportation and difficult terrains</td>
<td>Lack of competent staff in antenatal and postnatal care EmONC, partograph use, management of small newborns and AFRH services</td>
</tr>
<tr>
<td>Lack of awareness among pregnant women and their partners on available RMNCAH services and the danger signs regarding pregnancy and delivery</td>
<td></td>
<td>Lack of AFRH services and poor attitude of HCWs towards adolescents</td>
</tr>
<tr>
<td>Poor reputation and satisfaction with health care services</td>
<td></td>
<td>Poor quality of MNCH services</td>
</tr>
</tbody>
</table>

¹ See Annex A
³ Mbeya region was divided into two regions Mbeya and Songwe in 2015.
⁵ Ibid.
Theory of change

The project team developed a theory of change (ToC) prior to the start of the project implementation by UNICEF Tanzania’s Health Section in consultation with KOICA and the Reproductive and Child Health Section of the Ministry of Health and Social Welfare (MoHSW) now known as Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC). UNICEF undertook a detailed desk review that provided a situational analysis of the barriers to maternal and newborn mortality in Tanzania, specifically in the two focus regions of the project, Mbeya and Songwe, and a review of evidence-based interventions that have demonstrated effective solutions to address maternal and newborn mortality. This served to inform the design and the development of the project ToC (see Annex I, for the revised ToC). The activities proposed for this project were based on evidence from existing research and interventions published in The Lancet 2005 that have proven to be effective at reducing maternal and newborn deaths. Broadly the activities implemented by the project included:

- Procurement and distribution of equipment for basic and comprehensive EmONC across 30 strategic health facilities and 154 dispensaries
- Minor renovations/refurbishment of rooms in 30 strategic health facilities and 154 dispensaries to provide quality RMNCAH services
- Training of HCWs to provide an essential package of MNCH and AFRH services
- Procurement of 11 ambulances for strategic health facilities in the project districts to improve the referral for obstetric and pediatric emergencies
- Support quarterly integrated RMNCAH supportive supervision by the district and regional supervisors and introduction of a mentorship program
- Support the development of Maternal and Perinatal Death Surveillance Reviews (MPDSR) guidelines, the establishment of quarterly, monthly and weekly maternal and perinatal deaths reviews, and implementation of follow-up action plans at the regional, district and facility levels
- Conduct facility-community dialogues (appreciative inquiry, etc.) and mobilization activities through community health workers (CHWs), village government authorities, and influential community members to act as advocates and facilitate emergency referrals in 30 strategic health facilities.
- Develop and conduct communication for behavior change through mass media and mobile communicators
- Implementation of a mobile phone Mama na Mwana (MnM) intervention to improve uptake of MNCH services and to get client feedback

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6 The ministry was merged with Ministry of Community Development, Gender and Children (MCDGC) to form the Ministry of Health, Community Development, Gender, Elders and Children.
7 Tanzania Newborn Health Situation Analysis (SiTAN) 2009-2019 (provided by UNICEF to the evaluation team).
9 The ambulances were distributed to health facilities under guidance of RHMT/CHMTs. While the majority (10 out of 11) ambulances were distributed to 10 of the 19 strategic health centers, the ambulance for Busokelo was provided to Itete Designated Council Hospital – the only hospital at the time serving two health centers and 19 dispensaries in the council. Old Itete hospital ambulance was assigned to Mwakaleli CEmONC facility. The ambulance for Kyela was involved in an accident and was written off.
Through each of these activities, the project aimed to achieve several outputs under each of the following three outcomes:

**Outcome 1: Improved availability and readiness of quality RMNCAH services**

1.1 Strategically selected health facilities are refurbished, equipped with and ready to provide quality EmONC services

1.2 Quality of focused antenatal and postnatal care services improved at health facilities

1.3 HCWs from the selected health facilities have improved knowledge and skills to provide essential MNCH and AFRH services

1.4 Quality assurance for integrated RMNCH services established in the targeted health facilities

1.5 AFRH services introduced and practiced in 30 health facilities and some of the 154 dispensaries

**Outcome 2: Increased utilization of RMNCAH services**

2.1 Pregnant women have access to obstetric emergency referral services

2.2 Pregnant women, including adolescents, have developed birth preparedness plans (BPPs)

**Outcome 3: Increased community awareness and demand for quality RMNCAH services**

3.1 Pregnant women know maternal (during pregnancy, delivery, and postpartum) and newborn danger signs and available RMNCAH services

3.2 Pregnant and lactating women can provide timely feedback about the services they received in health facilities using the MnM intervention

As a result of achieving these outcomes, the project aimed to contribute to the reduction of maternal and newborn child deaths in Tanzania at the impact level (see Annex I for the revised ToC).

**Project resourcing**

The total project budget was $5,650,000, of which $5,231,481 was allocated for programmable costs. As of March 2020, the project had spent 99% of the funds ($5,593,500).10

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10 The project implementation ended in June 2019, after which a no-cost extension was issued to accommodate the completion of the endline evaluation.
2. Evaluation approach

2.1 Purpose and objectives of the evaluation

The purpose of the evaluation is to generate substantive evidence and lessons learned on the relevance, effectiveness, efficiency, sustainability, gender, and equity focus of the “Saving mothers’ and children’s lives through innovative, sustainable and comprehensive reproductive, mother, child and adolescent health services” project.

Specifically, the objectives of the evaluation were three-fold:

(iv) Determine the relevance, effectiveness, efficiency, sustainability, gender and equity focus of the project;

(v) Assess the integration of critical organizational principles and approaches, namely equity and gender in project planning, implementation and monitoring; and

(vi) Document good practice, lessons learned, and provide actionable recommendations for improvements of future anticipated project design and advocacy for scaling up.

The primary audience of this evaluation includes the MOHCDGEC, the President’s Office, Regional Administration and Local Government (PORALG), the UNICEF Tanzania Country Office, and KOICA.

2.2 Evaluation questions

The main and sub-evaluation questions are presented against the Organization for Economic Cooperation and Development - Development Assistance Committee (OECD-DAC) criteria in Table 2.11

Table 2: Evaluation questions

<table>
<thead>
<tr>
<th>Main questions</th>
<th>Sub-questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Relevance</td>
<td></td>
</tr>
<tr>
<td>1.1 To what extent are the project design, results, and implementation strategies relevant to the national and sub-national contexts, strategies, policies, and programs?</td>
<td>1.1.1 To what extent are the project design and results relevant to the target beneficiaries?</td>
</tr>
<tr>
<td>1.1.2 To what extent are the project design, results, and implementation strategies aligned with the national and sub-national contexts, strategies, priorities, policies, and programs?</td>
<td></td>
</tr>
<tr>
<td>2. Effectiveness</td>
<td></td>
</tr>
<tr>
<td>2.1 To what extent have the project’s objectives and intended results been achieved?</td>
<td>2.1.1 To what extent have the project activities improved availability and readiness of quality RMNCAH services in the project supported health facilities and dispensaries?</td>
</tr>
<tr>
<td>2.1.2 To what extent have project activities improved utilization of RMNCAH services in the project supported health facilities and dispensaries?</td>
<td></td>
</tr>
<tr>
<td>2.1.3 To what extent have project activities improved community awareness and demand for quality service by users in project supported communities?</td>
<td></td>
</tr>
<tr>
<td>2.2 What are the factors that facilitate or inhibit the achievement of the project’s objectives and expected results?</td>
<td>2.2.1 What factors have facilitated the achievement of the project’s objectives and expected results?</td>
</tr>
<tr>
<td>2.2.2 What factors have inhibited the achievement of the project’s objectives and expected results?</td>
<td></td>
</tr>
<tr>
<td>2.3 Which project activities had more significance to contribute towards improving availability, utilization, and community awareness and demand for quality RMNCAH services in Mbeya and Songwe regions?</td>
<td>2.3.1 Which project activities, targeted at improving availability and readiness of quality RMNCAH services, had the most significance?</td>
</tr>
</tbody>
</table>

11 See Annex C for the full evaluation matrix.
## Main questions

### 2.4 How effective have the M&E framework/components of the project been at assessing results?

- **2.4.1** How well was the M&E framework designed to allow the project to measure and assess the performance of the projects?
- **2.4.2** In what ways did the project use the ongoing monitoring data and the mid-term review to inform the design, implementation, and decision-making throughout the project implementation?

### 3. Efficiency

#### 3.1 How effective were key partnerships and coordination mechanisms to realize the project objectives?

- **3.1.1** To what extent has the coordination between national and sub-national government and working through government systems and processes enabled or inhibited the achievement of the project objectives?
- **3.1.2** To what extent has the partnerships and coordination with MNCH organizations enabled or inhibited the achievement of the project objectives?

#### 3.2 How adequate has UNICEF’s support been to the project, including from the perspectives of different partners at national and sub-national levels?

- **3.2.1** Technical: Was the technical support (i.e., building the technical capacity of health service providers on essential maternal, newborn, and AFRH services) adequate to achieve the outcomes of the project?
- **3.2.2** Capital investment: Was the capital investment in refurbishing or renovating strategic health facilities/dispensaries and procuring essential equipment adequate to achieve the outcomes of the project?

#### 3.3 To what extent have the project management and coordination been efficient?

- **3.3.1** To what extent has UNICEF’s coordination at the national and sub-national levels and with other MNCH partners been efficient?

#### 3.4 Are there feasible options for cost reduction and cost-saving specifically in relation to the capital infrastructure while realizing the same level of quality and results?

### 4. Equity and Gender

#### 4.1 To what extent have the project design and interventions taken into account the most vulnerable and hard to reach population?

- **4.1.1** To what extent has UNICEF’s project design and interventions taken into account the needs of pregnant teens?
- **4.1.2** To what extent have rural, hard-to-reach women and adolescent girls been targeted?
- **4.1.3** To what extent have uneducated women and adolescent girls been targeted?
- **4.1.4** To what extent have HIV prevention and quality of care to HIV-positive pregnant adolescent girls and women been targeted?
- **4.1.5** To what extent have poor families been reached by the project?
- **4.1.6** To what extent have women and girls affected by disabilities been reached?

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12 BBC Media Action, Liverpool School of Tropical Medicine and Ifakara Training Centre for International Health.
2.3 Evaluation design

The focus of the endline evaluation was to examine and measure the contribution realized on positive maternal and newborn health outcomes in Mbeya and Songwe regions, from March 2015 – June 2019. We employed a Theory-Based Evaluation (TBE) approach, which used the project ToC to conclude whether and how the interventions contributed to the outcomes of the project. The TBE approach allowed us to examine the relationships between the project activities, outputs and outcomes, and further the mechanisms of change, as well as the assumptions, risks and contexts that support or hinder the theory from being manifested. We utilized mixed methods, i.e., quantitative, qualitative, and secondary data sources (e.g., project monitoring data and policy documents) to address each of the evaluation questions outlined above and in the evaluation matrix in Annex C.

2.4 Methodology

2.4.1 Quantitative Methods

Our quantitative approach involved a (i) health facility survey and (ii) household survey.

i. Health facility survey

The health facility survey assessed how the supply side interventions aimed at improving the availability of EmONC for life-saving interventions and essential RMNCAH equipment and supplies in high client volume health facilities and smaller facilities have contributed to improved availability and readiness of quality RMNCAH services. The survey also captured data on the utilization of RMNCAH services in the targeted health facilities over the course of the project.

At the health facility level, we conducted an interview with the head of the health facility or lead provider working in the maternity or reproductive child health section. We employed the same health facility survey instrument used at baseline with some minor revisions suggested by the evaluation team (see Annex E). The tool captured the state of the infrastructure, availability of RMNCAH services, the required equipment,
supplies, and drugs for essential RMNCAH services, utilization rates over the past three months, EmONC signal functions provided, number of women and newborns delivered, maternal complications due to direct obstetric causes, maternal and newborn deaths, and referrals.\textsuperscript{13}

At baseline, the health facility survey was conducted in 41 health facilities, including 30 strategic health facilities (19 health centers and 11 dispensaries) and 11 district and mission hospitals where complicated cases are referred. The 11 district and mission hospitals were not among the health facilities targeted by the project. Therefore, they were not included as part of the endline sample for the health facility survey.

To allow for ‘pre-’ and ‘post-’ comparison, the endline sample for the health facility only covered the same 30 facilities – 19 health centers and 11 dispensaries covered at baseline and targeted by the project. (See Annex G for the list of health facilities surveyed at endline.)

\textbf{Household survey}

We undertook a household survey with 480 households across all 12 districts to assess how the project interventions aimed at improving community awareness and demand for quality RMNCAH services contributed to increased knowledge, attitudes and practices among pregnant and lactating women with regards to accessing medical care (i.e., prenatal, antenatal, post-natal care, delivering at health facilities, and utilization of health facilities). The household instrument also captured the views of adolescent girls on AFRH services at the health facilities targeted by the project. To capture a ‘before and after’ story or trend, we wanted to ensure that the household survey utilized at endline was adapted from the instrument employed at baseline. As part of the inception phase, we conducted a review of project documents and the results framework, which informed our revision to the household instrument. Edits were made to the household tool in collaboration with UNICEF. The comprehensive tool captured relevant data to assess the contribution story of the project. (See Annex E for the revised household survey tool that was used at endline assessment.)

We undertook two approaches in testing for balance between the baseline and endline samples (see Annex D for details on the approach taken and the sample characteristics). Overall, we found those in the endline sample were more educated, wealthier, employed, younger in age, and lived in more urban areas than those in the baseline sample. These differences are likely to impact the outcome indicators relating to the utilization of health facilities during pregnancies and also awareness and demand for services. Therefore, it is essential to apply caution when interpreting the results.

\textbf{2.4.2 Qualitative Methods}

We employed qualitative methods primarily through conducting key informant interviews (KII), in-depth interviews (IDI), and focus group discussions (FGD) to elicit information from various project stakeholders and beneficiaries on the success or failure of project interventions. We undertook a purposive sampling approach to ensure that the broadest range of views, attitudes and experiences of the qualitative participants were captured; this included sampling at the community, regional/district and national levels, and including UNICEF staff and MNCH partners. (See Annex B for further details on the sampled respondents and Annex E for the qualitative instruments employed at endline.)

\textbf{2.5 Research ethics}

In December 2019, following the finalization of the inception report, we applied for ethical clearance from the Tanzanian National Institute of Medical Research (NIMR), and approval was given in February 2020. Once the ethical clearance certificate was issued by the NIMR, we submitted a copy of the certificate to the corresponding regional and district officials prior to engaging in fieldwork.

\textsuperscript{13} Kilimanjaro Christina Medical University College, Baseline Assessment of RMNCAH services in Mbeya Tanzania – February 2016.
The evaluation team adhered to the United Nations Evaluation Group’s norms and standards for evaluations as well as UNICEF Procedure for Ethical Standards in Research, Evaluation, and Data Collection and Analysis. All evaluation team members underwent ethical training before the survey commenced.

As this research involved working with vulnerable populations, specifically adolescent girls aged 15-19, the study also underwent a Data Protection Impact Assessment internally at Kantar as part of our data protection policy. This review included a closer look at steps that were being taken to ensure consent from minors and vulnerable populations was being sought in the right way, and how the data would be managed, stored, and used. Following the internal review and approval of the stated process, the study was able to proceed.

We employed principles and practices of do no harm, informed consent, confidentiality and privacy, protection and duty of care, fairness and respect, and issue of practical benefit and flexibility throughout the study. (See Annex H for the research ethics approach taken and the ethical approval certificate for the study.)

2.6 Limitations of the evaluation

The limitations of the evaluation are as follows:

- **Comparability of baseline data to the endline:** To achieve maximum comparability with the baseline, it was important that data collection at endline (i.e., sampling approach, instruments, and field staff training) followed a similar approach as the baseline. As a result, the evaluation drew heavily on the information available from the baseline report. With regards to the sampling approach and field reports followed at baseline, information and documents we requested from the institution that conducted the baseline assessment were not available. As such, we carried out the work based on what was described in the baseline report methodology section. Without reference to field reports or the master sample frame, however, we could not be certain all aspects of the endline mirrored the baseline approach. This is also indicated in the imbalance in both the baseline and endline samples that we saw at endline. Therefore, it is important to be cautious in interpreting the results of this study as some bias does exist, and therefore, the results might be over or underestimating the impact of the project on the key outcomes.

- **Attribution claims are not possible:** The evaluation design does not follow a counterfactual analysis that allows measuring what would have happened in the absence of the project. Therefore, we only make claims on how the project contributed to the key outcome indicators, and we do not make any attributional claims.

- **External factors:** There was some difficulty in identifying and measuring the contribution of external factors on the observed results. For the contribution story to hold, we had to identify and measure the contribution of other external factors that could affect the observed results; thus, we employed various data collection approaches and worked closely with the client, key stakeholders, and beneficiaries to capture as much information as possible on other programs or projects taking place in the target regions.

- **Access to baseline health facility data:** The evaluation team was not able to get access to the baseline health facility data. As a result, we have had to manually pull data from the baseline report to make comparisons with the endline data. Our analysis comparing baseline and endline indicators for outcome 1 is limited to the data we were able to extract from the baseline report.

- **Quality of baseline household dataset:** The baseline household data was made available to Kantar. However, the data received was not fully cleaned and did not come with a codebook. As such, based on the baseline questionnaire available in the baseline report, we had to clean the data for indicators of interest, which included coding open-ended questions, correcting spelling errors due...
to data entry errors, recode options to missing due to data entry errors, and in some cases dropping observations that we could not use as part of our analysis.

- **Key informants not available for interview:** A few informants were not available for the KII s due to the following reasons: they were on leave, too busy, or declined to be interviewed for reasons such as "not being well informed about the project." As a result, in a few instances, it was not possible to ascertain and crosscheck the information collected from other informants.

- **Change of leadership and staff turnover in implementation regions and districts:** A high proportion of Regional Health Management Team (RHMT), Council Health Management Teams (CHMT), national, regional, district and health facility staff had either retired or transferred to another post outside the target regions. This reduced the ability to take advantage of institutional memory around the project, limiting the evaluation of some contextual and background information that could have added value to the findings.
3. Key findings

In this section, we discuss the key findings by each of the five evaluation criteria: (i) relevance, (ii) effectiveness, (iii) efficiency, (iv) gender and equity, and (v) sustainability. Within each evaluation criterion, we present the findings by evaluation questions.

3.1 Relevance

The evaluation sought to answer the question on the extent to which the project design, results, and implementation strategies were relevant to the national and sub-national contexts, strategies, policies, and programs. To address this question, we looked at relevance from the national and sub-national policy, strategy, country context, and implementation perspective and from the perspective of the target beneficiaries.

3.1.1 To what extent did the project design, results, and implementation strategies align with the national and sub-national contexts, strategies, priorities, policies, and programs?

Policy and priority perspective

The UNICEF/KOICA project was aligned with Tanzania Development Vision 2025, which among other social and economic development goals, prioritizes reducing maternal, neonatal, and child mortality through the implementation of high impact interventions. Vision 2025 stresses its commitment to improving access to quality reproductive health services to all individuals of appropriate age and reducing maternal and infant mortality by three-quarters by 2025. This commitment continues to be reflected in every five-year development plan since 1996. The Tanzania Health Policy (2007), as well as the New Health Policy Draft (2020), has stressed RMNCAH as the country’s highest health sector priority, attributed to the alarmingly high maternal mortality ratio. The policy is outlined in detail in the Health Sector Strategic Plan III and later IV, which placed RMNCAH topmost on its agenda (MOHCDGEC, 2015).

The Tanzania National eHealth Strategy (2013) focuses on improving the quality and efficiency of health care delivery and prevention programs through accurate, timely and secure delivery of relevant health information. Specifically, Strategic Objective (SO) 7 under this strategy focuses on enabling electronic delivery and interventions of health services to reduce child and maternal mortality, and the burden of HIV/AIDS, TB, malaria, and non-communicable diseases. The project was aligned with the national eHealth strategy and the mobile-based platform, MnM, used during the project, was specifically relevant to addressing SO 7. The MnM service used SMS services via mobile phones to educate pregnant women and mothers who recently delivered a baby, about the danger signs regarding their pregnancies or post-delivery complications, and was used to send reminders about upcoming PNC and ANC. The service also served as a social accountability platform for local government authorities by allowing women who had currently delivered or used the service at a health facility to provide feedback on the quality of care received.

Strategic plans perspective

The implementation of the UNICEF/KOICA project coincided with the implementation of Tanzania’s One Plan II, a road map for improving RMNCAH in Tanzania (2016 - 2020). This strategic plan was developed to harmonize efforts by different development and implementing partners who support Tanzania in improving RMNCAH services for better coordinated RMNCAH programming as well as attaining optimal outcomes from pooled resources. Thus, every partner was expected to align their support and activities within the framework of One Plan II.

The One Plan II road map outlined 11 programmatic areas that constitute the country’s key priorities for achieving desirable outcomes for RMNCAH services and programs The UNICEF/KOICA project design and

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implementation strategies/interventions aligned with nine out of the 11 programmatic areas, as shown in Table 3.

Table 3: Alignment of project interventions with national programmatic areas of focus

<table>
<thead>
<tr>
<th>National programmatic area of focus</th>
<th>Alignment of the UNICEF/KOICA project with national programmatic areas of focus</th>
<th>UNICEF/KOICA project's relevant interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Maternal Health</td>
<td>Yes</td>
<td>Refurbish and provide essential EmONC equipment to 30 health facilities and all 154 dispensaries. Support the development of MPDSR guidelines and conduct regular maternal and perinatal death reviews. Procure and donate 11 ambulances to strategic health facilities in project districts. Develop and distribute information education communication (IEC) materials on BPP.</td>
</tr>
<tr>
<td>2. Newborn Health</td>
<td>Yes</td>
<td>Support the development of MPDSR guidelines and conduct regular maternal and perinatal data reviews. Training/capacity-building of KMC services.</td>
</tr>
<tr>
<td>3. Child Health</td>
<td>Yes</td>
<td>Training/capacity-building of service providers and health managers. Support regions and districts to conduct regular supportive supervision and mentorship.</td>
</tr>
<tr>
<td>5. Family Planning</td>
<td>No</td>
<td>No specific interventions relating to family planning. Addressing family planning is not part of UNICEF’s mandate.</td>
</tr>
<tr>
<td>6. Reproductive Cancer</td>
<td>No</td>
<td>No interventions relating to reproductive cancer, the project focused on was on RMNCAH.</td>
</tr>
<tr>
<td>7. Gender and Male Involvement</td>
<td>Yes</td>
<td>Conduct facility-community dialogue. Implement a mobile phone MnM intervention to improve uptake of MNCH services and get client feedback. Communication for behavior change through mass media and mobile communicators.</td>
</tr>
<tr>
<td>8. Leadership and Governance</td>
<td>Yes</td>
<td>Support regions and districts in conducting regular supportive supervision and mentorship.</td>
</tr>
<tr>
<td>9. Development of Human Resources for Health (HRH)</td>
<td>Yes</td>
<td>Train health care workers on selected RMNCAH packages and on the provision of quality care.</td>
</tr>
<tr>
<td>10. Health Financing</td>
<td>Yes</td>
<td>UNICEF is a major source of funds in target regions and councils medium-term expenditure frameworks in the area of MNCH</td>
</tr>
<tr>
<td>11. Monitoring and Evaluation</td>
<td>Yes</td>
<td>Support regions and districts in conducting regular supportive supervision and mentorship.</td>
</tr>
</tbody>
</table>

Country context analysis

The project was designed and implemented at a critical time, during which Tanzania was witnessing very high maternal and neonatal mortality rates (Table 4). The high numbers of maternal and neonatal deaths are still prevalent today and are due to preventable/treatable causes such as hemorrhage, hypertension, abortion, and sepsis. Causes of under-five deaths include newborn complications, pneumonia, malaria, diarrhea, malnutrition and HIV/AIDS. Newborn deaths are primarily due to three causes: birth asphyxia, complications of prematurity and sepsis. The causes of newborn deaths are closely linked to the health of both the mother and baby during pregnancy, delivery, and the first week of life. Relative to the national

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16WHO and CHERG neonatal and child cause of death estimates. WHO Global Health Observatory.
figures, the targeted regions for the project, Mbeya and Songwe (originally Mbeya region until the split in 2016), had very high maternal and neonatal mortality rates, close to the national figures.

### Table 4: Key indicators on maternal and newborn care in Tanzania and Mbeya region

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-five mortality rate (per 1,000 live births)</td>
<td>92</td>
<td>67</td>
<td>78</td>
<td>97</td>
<td>72</td>
<td>95</td>
</tr>
<tr>
<td>Infant mortality rate (per 1,000 live births)</td>
<td>60</td>
<td>46</td>
<td>51</td>
<td>71</td>
<td>49</td>
<td>77</td>
</tr>
<tr>
<td>Neonatal mortality rate (per 1,000 live births)</td>
<td>28</td>
<td>-</td>
<td>29</td>
<td>41</td>
<td>-</td>
<td>39</td>
</tr>
<tr>
<td>Maternal mortality ratio (per 100,000 live births)</td>
<td>454</td>
<td>432</td>
<td>556</td>
<td>-</td>
<td>776</td>
<td>-</td>
</tr>
</tbody>
</table>

Note: Mortality rates/ratio estimates are for a 10-year period preceding the survey/Census.

The main underlying reasons for these deaths are poor availability, accessibility, and quality of health care, and delays in decision making and/or reaching a health facility primarily due to lack of awareness, prohibitive cost, lack of family/community support and lack of transport. Although Tanzania’s National Health Policy of 2007 outlines free maternity and under-five health services, due to the lack of easily accessible maternity-related services close to home, particularly in rural areas, many families incur a huge transportation-related cost to reach health facilities. In addition, when at the facilities, women might have to purchase prescribed medication/supplements if the health facility is out of stock. As a result, home delivery with the assistance of traditional birth attendants is a preferred option for some families who can’t afford to pay for the transport or cost of supplies needed for childbirth (e.g., gloves, mackintosh, cotton wool, scalpel and cord tie, etc.)

Although the proportion of skilled attendants assisting deliveries has increased in Tanzania from 51% to 64% from 2010 to 2015-16, respectively (TDHS-MIS 2015-16), these rates are still below the national target of 80%. In the Mbeya region, the proportion of women who received assistance from a skilled attendant during delivery was 65% (TDHS-MIS 2015-16). Despite skilled attendants assisting during delivery has improved, women delivering at health facilities do so under unhygienic conditions, which are documented as critical factors contributing to the high maternal and neonatal mortality rates through sepsis. According to a UNICEF fact sheet (2016), unhygienic conditions contributed to up to 20% of neonatal deaths.

Significant rural-urban and regional disparities exist on a number of maternal and newborn health outcome indicators across Tanzania. At the onset of the project, there was high regional disparity and urban-rural inequity in access to available maternal and child health services across the country. Some of the urban-rural disparities include the number of facility deliveries (68% versus 34%, respectively) and PNC (27% versus 16%, respectively). Similarly, with a deficit of human resources for health at 52%, only 55% of available human resources for health were recorded to be serving in rural areas where 75% of the total population lives, and these are mostly less-skilled providers (MoHSW, 2013).

Tanzania has one of the highest adolescent (ages 10 to 19) pregnancy rates in the world, affecting girls’ health, education, future employment, and their ability to reach their full potential in life. By the age of 19, approximately one-quarter (23%) of girls have started childbearing, and 44% are either mothers or pregnant with their first child (TDHS 2010). Adolescents also constitute a third of incomplete abortion cases recorded

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17 Note: Until 2016, Mbeya and Songwe were one region. In 2016, Mbeya split into two regions, Mbeya and Songwe.
in health facilities, with one in five of the girls involved being a student.¹⁸ Most of the reproductive health services available in Tanzania are adult-centered, thus making them less accessible to adolescent girls and boys. Other barriers include the lack of knowledge specific for adolescents among service providers, rejection by the service providers, and community perceptions on the provision of such services to people considered still to be "children." Thus, the capacity building of HCWs on the provision of AFRH services and providing appropriate knowledge on sexual reproductive health to adolescent girls and boys were deemed important to contribute to the reduction of maternal, newborn, and child mortality.

**Project design and implementation strategy**

The project design was guided by three broad criteria: mode of implementation, selection of a set of interventions, and identification of geographical areas for implementation.

**Mode of implementation**¹⁹

UNICEF managed the project using existing internal structures that are aligned with the Tanzanian health system. UNICEF’s experience working closely with the GoT through MOHCDGEC and local government authorities in a broad spectrum of health and social development programs has contributed to its successful collaboration and partnership with the GoT as well as with other implementing partners.

The project worked in close collaboration with the PORALG, MOHCDGEC, local government authorities in Mbeya and Songwe regions, and other MNCH partners, specifically Tanzanian Training Center for International Health (TTCIH)-Ifakara, Liverpool School of Tropical Medicine (LSTM), BBC Media Action, Chama cha Uzazi na Malezi Bora Tanzania (UMATI) and Support for Medical Affairs for Indonesians (SIMAVI). UNICEF partnered with UMATI on the community-based interventions and LSTM on the EmONC training.

**Selection of a set of interventions**

**The design and selection of interventions were made in consultation with the regional and district council officials.** At the design stage of the project, UNICEF engaged with both regional and district council officials to identify the areas for improvement in RMNCAH services. As a result of this consultation, the project designed activities in five strategic intervention areas: (i) refurbishment /renovations of the facility, (ii) provision of equipment, (iii) provision of training, (iv) re-allocation of necessary human resources (by the government as per the commitment of district and regional authorities) and (v) quality improvement measures. Both regional and district council level officials from the KIIIs noted the project activities were relevant and aligned with the needs of the district councils and addressed key RMNCAH areas that required improvements.

**Strategic selection of health facilities for improvement**

The project supported a total of 184 health facilities (health centers and dispensaries) across Mbeya and Songwe region. Among these 184 facilities, 30 health facilities were strategically chosen, in consultation with the regional and district officials, to receive larger support in terms of renovations, refurbishments, equipment, and training support. The facilities targeted for larger support were selected because they provide access to health care to areas that are peripheral and remote, they are high volume sites in terms of outpatient load and deliveries and have added challenges around transport for emergency referrals that need to be addressed. The remaining 154 dispensaries received some minor refurbishments and procurement of essential equipment was identified via a rapid facility assessment conducted during the midterm review of the project (2017). Of the 154 dispensaries, only 15 received the minor refurbishments. In addition, ten district hospitals that serve as referral facilities for the 184 project facilities were earmarked to

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¹⁹ The mode of implementation included how the project was organized, coordinated, supervised, monitored, and reported.
receive capacity building and equipment support to enable them to provide Kangaroo Mother Care (KMC) services. Regional and district level officials deemed the participatory approach taken by UNICEF to involve them in the selection of the strategic facilities as useful towards improving the quality of RMNCAH services.

3.1.2 To what extent were the project design and results relevant to the target beneficiaries?

The target beneficiaries for this project were pregnant women, newborn babies, children under age five and adolescent girls and boys in the former ten districts in Mbeya region (now 12 districts across Mbeya and Songwe regions). The project was designed to address barriers that limit target beneficiaries’ access, utilization, and availability of quality RMNCAH services. The key barriers faced by the target beneficiaries in accessing and using RMNCAH services include the absence of or inadequate RMNCAH services, lack of equipment, poor customer service/hospitality and treatment by HCWs, lack of amenities, including water, sanitation and electricity, delayed or inaccessible services due to distance or poor roads, and negative cultural beliefs and practices around women delivering at health facilities. Project activities were designed to align with and address these barriers, which were outlined by women in the baseline survey (2014-15).

Drawing on the qualitative interviews with target beneficiaries, the following discusses the relevance of each of the project activities under each of the outcomes.

Perceived relevance on outcome 1: Improved availability and readiness of quality RMNCAH services

Respondents in the FGDs and IDIs reported the refurbishments and renovations of the health facilities had provided them with much-needed space for hygienic services for maternal and neonatal services. The procurement and availability of essential equipment and testing kits such as delivery beds, weighing machines, hemoglobin testing kits, delivery kits, operating room equipment, and blood refrigerators have resulted in improved quality of service provision and have contributed to saving the lives of mothers and newborns. Women also noted improvements in the attitudes and customer service/hospitality of HCWs resulting in a more friendly environment that has influenced the utilization of services.

In addition, beneficiaries also noted the contribution of improvements in necessary amenities at the health facilities such as water, electricity, and proper sanitation services, which not only have improved the hygiene and sanitation of the health facilities but have also contributed to the quality of services provided.

Perceived relevance on outcome 2: Improved utilization of RMNCAH services

At baseline, women noted that among the key reasons most women do not seek RMNCAH services earlier in their pregnancies were a lack of knowledge of the danger signs around pregnancy and the lack of proper planning for birth. Women also reported having delivered at home or on their way to the health facility due to the lack of transportation to the health facilities, particularly when labor started in the evening. The project interventions have directly targeted these barriers by implementing activities to increase awareness and knowledge of danger signs during pregnancies, counseling women to prepare their BPPs and providing 11 ambulances for emergency obstetric and neonatal referrals to the target project facilities. The target beneficiaries interviewed stated that some of the direct benefits of the project were improved knowledge around the danger signs during pregnancy and how to develop a BPP so they could better prepare for their delivery.

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Perceived relevance on outcome 3: Increased community awareness and demand for quality services

The project addressed socio/cultural barriers to allowing women to make their own decisions about when to seek RMNCH services and the traditional norms of delivering at home through a series of awareness creation activities. The activities were designed to change the knowledge, attitudes, and practices of not only women of reproductive age and adolescents, but also their husbands/partners, fathers/mothers-in-law, other family members, and community members who are social influencers. The activities included the use of mass media, IEC materials, community and facility dialogues, and MnM services to sensitize the community on the benefits of RMNCAH services and create demand for these services in the process. These activities were influential in improving community awareness and demand for quality services, particularly the community and facility dialogues, which engaged not only women, but the wider community, including men, mothers/fathers-in-law, and village elders around RMNCAH services.

It is clear from the interviews conducted with target beneficiaries and some of the findings from the quantitative data in the sections below, that the project design and results are relevant to the target beneficiaries. The project was designed to cater to the challenges that were identified by women and members of the community, and the results observed confirm the project addressed the needs of the beneficiaries in the targeted communities.

3.2 Effectiveness

Under effectiveness, the evaluation sought to answer the extent to which the project objectives and intended results have been achieved, what are the factors that facilitate or inhibit the achievement of the project objectives and expected results, and which project activities had more significance to contribute to the key outcomes. We draw on the quantitative, qualitative, and secondary data to address these evaluation questions for each outcome in this section.

3.2.1 To what extent were the project objectives and intended results achieved?

Outcome 1: Improved availability and readiness of quality RMNCAH services

In this section, we present the findings on how the UNICEF/KOICA project has contributed to improved availability and readiness of quality RMNCAH services in Mbeya and Songwe regions. We draw on quantitative data from the health facility survey and qualitative interviews at the health facility and regional/district level.

Table 5 presents a summary of the baseline and endline achievements for the outcome 1 indicators against targets set by the project. The project has achieved the targets for three out of the five indicators under outcome 1. We discuss each of the indicators further below.

Table 5: Outcome 1 indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline</th>
<th>Endline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. # of health facilities providing all 7 BEmONC functions</td>
<td>0</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>1b. # of health facilities providing all 9 CEmONC functions</td>
<td>0</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>1c. (i) # of health facilities which use partographs in delivery rooms&lt;sup&gt;20&lt;/sup&gt;</td>
<td>100%</td>
<td>100% (30/30)</td>
<td>100% (30/30)</td>
</tr>
</tbody>
</table>

<sup>20</sup> This indicator was not included in the original PDM (result framework), was added in the results matrix in the first annual report. Baseline values vary across the annual reports, see Annex J for further details.
Indicators | Baseline | Endline | Target
--- | --- | --- | ---
1d. (ii) # of deliveries with partographs correctly filled during the last year | 50% (Good) | 100% (Excellent (55%) and Good (45%)) | 80%
1e. % of health facilities which provide AFRH services | 0% | 100% (30/30) | 50% (15/30)

**Capacity to provide BEmONC signal functions**

At baseline, none of the 30 strategic health facilities could perform the seven BEmONC signal functions—the project aimed for all 30 strategic health facilities to have this capacity by the endline. To enhance the capacity of the 30 strategic health facilities to provide all of the BEmONC signal functions, the project supported facilities through major renovations and refurbishments, procurement and distribution of essential equipment, and training of HCWs via two-week BEmONC training as well as short skilled based EmONC refresher training. The training provided was further strengthened through supportive supervision and clinical mentorship sessions to ensure knowledge retention.

As a result of the support provided to the 30 health facilities, 18 out of the 30 facilities (60%) had the capacity to provide all seven BEmONC signal functions by the endline (Table 5). Among the remaining 12 facilities, the most common BEmONC signal functions not performed were those related to the removal of retained products by Manual Vacuum Aspiration (MVA), Assisted Vacuum Delivery (AVD) and Manual Removal of the Placenta (MRP) (Figure 1).

- **AVD**: Twenty-one out of 30 strategic health facilities now perform AVD, which is a major improvement from baseline, when all 30 health facilities did not perform this signal function (Figure 1). Most facilities were reported to have vacuum extraction equipment at baseline; however, they were not in use due to a lack of confidence among HCWs in their ability to properly use the equipment. For facilities where the equipment was not available, UNICEF procured and distributed the equipment. HCWs across the 30 strategic health facilities received training on AVD; however, nine out of the 30 health facilities reported not being able to conduct AVD, of which seven facilities did not have a functional vacuum extractor and no staff (i.e., nurses/midwives and clinicians) who can perform the service, whereas two facilities had the functional equipment but no staff to perform the function.

- **MVA**: Twenty-two out of the 30 strategic health facilities had the capacity to perform MVA at the endline relative to seven facilities at baseline (Figure 1). All 30 strategic health facilities received training on MVA as part of the project implemented through the regional and district health management teams and LSTM. Among the eight facilities that did not have the capacity to perform MVA, the lack of functional MVA kits was cited. Due to UNICEF’s pro-life policy and potential misuse of the kit, the project did not provide MVA kits to health facilities that did not have them. The procurement and distribution of these kits needed to be provided by the regional and district governments.

- **MRP**: The number of health facilities capable of performing MRP increased from 26 at baseline to 28 at endline (Figure 1). Two facilities, Iyula health center and Ukwavila Dispensary could not perform MRP at endline due to the lack of skilled personnel to perform the function. Although the project trained HCWs across the 30 strategic health facilities on MRP, the lack of skilled personnel is likely caused by either staff transfers or turnover.

21 In the original PDM (result matrix) this indicator is % of deliveries with partograph correctly filled during last month and was subsequently changed in the annual reports that followed. We assessed a sample of five partographs to evaluate whether they were correctly filled or not.

22 Reporting is based on responses provided by the health facility.
Although the project has made significant strides in improving the capacity of the 30 strategic health facilities to provide the seven BEmONC signal functions, it did not meet its target for the three EmONC functions (i.e., MVA, AVD and MRP), resulting in only 18 out of the 30 facilities capable of providing all seven BEmONC signal functions at endline as shown in Figure 1.

**Figure 1: BEmONC signal functions offered by the 30 strategic health facilities in the past 12 months**

![Bar chart showing the number of health facilities offering different signal functions at baseline and endline](chart.png)

**Capacity to provide CEmONC signal functions**

The project targeted seven out of the 30 strategic health facilities to be upgraded to CEmONC status (i.e., providing all nine signal functions by endline). These facilities were Ibaba, Kamsamba, Tunduma, Mbuyuni, Utengule, Mwakaleli, and Ipinda health centers. To achieve this, the project supported the target facilities with renovation/refurbishment of operating theatres and procurement and distribution of essential equipment required for CEmONC services including obstetric surgical kits, operating tables, anesthesia machines, blood refrigerators and freezers, generators, among others. The support also included task-shifting training for C-section and anesthesia for HCWs across the targeted health facilities.

As a result of the support provided, five of the seven strategic health facilities were capable of providing C-sections and six of the facilities were able to provide blood transfusions at endline. However, three facilities out the seven did not achieve two of EmONC signal functions (i.e., AVD and MVA, which resulted in only three out of the seven targeted facilities being capable of performing all nine CEmONC signal functions.

- **C-sections**: Five out of the seven strategic health facilities were performing C-sections at endline, relative to only one facility at baseline (Figure 2). With the exception of the Ipinda health center, all six health facilities could not perform C-sections at baseline. Given the existing capacity of the Ipinda health center to perform C-sections at baseline, the project only strengthened the capacity of this health facility at the request of the region and district officials by providing equipment to and training on BEmONC and CEmONC, and short skills on EmONC, plus providing an ambulance. At the endline, only the Ibaba and Mbuyuni health centers were not providing C-section services. Buildings renovated with UNICEF/KOICA support were put to other use, since both facilities, benefited from greater government support and were allocated a large amount of funds to construct a minimum number of new planned buildings, including an operating theatre which is due to start operating in July 2020. In addition to the targeted seven facilities, the Mbeya District Council identified two strategic health centers, Inyala and Ilembo health centers, to provide CEmONC functions and had operating theatres constructed by the district council at the start of the project. The UNICEF/KOICA project, at the recommendation of the RHMT, included these two facilities to benefit from the task-shifting training and also to receive theatre equipment to enable obstetric surgery to be performed.
- **Blood transfusion:** Six out of the seven health facilities could provide blood transfusion at the endline, which is a major improvement from the baseline when only one facility could provide this service (Figure 2). All six facilities reported having a functional refrigerator to store blood and four out of the six health facilities had a thermometer available to maintain the temperature of the refrigerator between 0 and 10 Celsius. Similarly, four out of the seven facilities reported having a standby stock of blood units.

- **AVD:** Two facilities, Mbuyuni health center and Kamsamba health center do not have the capacity to perform AVD due to the lack of functional vacuum extractors (Figure 2).

- **MVA:** One out of the seven health facilities (Mwakaleli health center) targeted for CEmONC does not perform MVA due to the lack of a functional MVA set (Figure 2).

While the project made significant investments in major refurbishments and renovations of operation theatres, procurement of equipment for C-section and blood transfusions functions, and training of HCWs to perform CEmONC level functions, it did not meet its target of all seven health facilities performing all nine CEmONC signal functions by endline (Figure 2).

**Figure 2: CEmONC signal functions offered by the seven strategic health facilities in the past 12 months**

See [Error! Reference source not found.](#) in Annex F for a summary of the signal functions offered by each of the 30 health facilities in the past 12 months, and further analysis of the summary of the signal function performed in the last three months prior to the survey.

**Use of partograph in the delivery room and quality of partograph filled**

Tanzania has adopted the WHO recommendation that during labor, skilled birth attendants (SBAs) should use the partograph as a tool to improve documentation of the progress of labor through intrapartum maternal and fetal measurements and to identify abnormalities to inform appropriate labor-management. All 30 health facilities used partographs in the delivery rooms at baseline. Although the endline project had a target of all 30 health facilities using partographs, this was already in place at the start of the project, so the aim was to maintain the already high level. At endline, all facilities reported using partographs routinely; however, we found that one facility (Ivuna Dispensary) has not used partograph for several months due to the lack of forms (Figure 3). The facility reported not having access to a printer or photocopy machine to duplicate the forms; hence they depend on the district hospital to supply the forms.

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23 Outside of the seven targeted health facilities for CEmONC upgrade, one facility, Madibira health center, also reported having capacity to provide blood transfusions.

The quality of the partograph was assessed at both baseline and endline, drawing on a sample of five completed partographs at the time of the survey. At baseline, 15 health facilities did not properly fill out the partographs observed and were designated as poor. At the endline, we see a significant improvement such that 17 health facilities filled out their partographs correctly and were rated as “excellent,” and 13 health facilities were rated as “good” (See definition for rating at the bottom of Figure 3). The rating was done by the interviewers, who were all qualified nurse-midwives. It is possible to assume that the training intervention conducted under the project made a contribution to this improvement. Quality use of partographs usually increases with practice coupled with continuous mentorship and supportive supervision. If these practices are sustained in the two study regions, this intervention may be able to pull all of the "good" ratings into the "excellent" category.

Figure 3: Availability of partographs at the 30 strategic health facilities and level of quality

![Partograph availability chart]

**Base:** Partograph availability: n=30  | Quality of 5 sample partographs: Baseline n=30 and Endline n=29. Note, quality of forms was not assessed for Ivuna Dispensary at endline since they had not used partograph forms in the past couple of months prior to the survey. Therefore, the sample size for level of quality is 29 for endline. Endline, rating definition: Excellent: five out of five partographs sampled were completed correctly; Good: four out of five were completed correctly; Poor: 3 or less out of the five were completed correctly.

**Adolescent-friendly reproductive health services**

In the RMNCAH continuum of care, AFRH services constitute a unique arm of reproductive health and psychosocial support that require both specialized training among service providers and a well-designated infrastructure for adequate provision of the services. According to the WHO, appropriately designed AFRH services should include components of service delivery, preventive care, a well-trained workforce, and a well-designated infrastructure and planned financing strategy. These considerations were among the planned and implemented interventions within the UNICEF/KOICA project.

UNICEF provided training on AFRH to all the 30 strategic health facilities and renovated a building at Ruanda health center to become a model AFRH service for Mbeya region. It should be noted here that, while these were the two main interventions by UNICEF, the knowledge acquired and the model at Ruanda health center became a stimulant for the regions to strengthen AFRH services in other health facilities.

At baseline, none of the 30 health facilities provided AFRH services; however, by endline, all facilities reported providing AFRH services. The project target was to establish AFRH services in 15 out of the 30 health facilities. By endline, the target number was nearly doubled, and AFRH services were being provided by 30 facilities. Among the 21 facilities that provided data on the number of adolescents that accessed the AFRH service in 2019, a total of 11,265 adolescents used the services, which is on average, about 530 adolescents per facility.

Most health facilities providing AFRH services did not have a separate waiting or consultation room (3% and 18% had separate waiting rooms at baseline and endline, respectively). However, to ensure the privacy and confidentiality of adolescents during the consultation, health facilities set aside specific days of the week and times for AFRH consultations. Facilities offered a range of services from counseling and testing for HIV to
reproductive health, including contraceptives, STI treatment, pregnancy care and post-abortion management. Other services offered included information and counseling on development during adolescence, including reproductive health, nutrition, hygiene, sexuality and substance use, management of sexual violence and general health service for tuberculosis, malaria, endemic diseases, injuries, accidents, and dental care.

**Contribution of the project to improving ANC, delivery and PNC services**

1. **Antenatal care**

Along the continuum of care for RMNCAH services, ANC is the first and most important intervention for the best outcomes of pregnancies. According to the World Health Organization, essential interventions in ANC include identification and management of obstetric complications such as preeclampsia, tetanus toxoid immunization, intermittent preventive treatment for malaria during pregnancy (IPTp), and identification and management of infections including HIV, syphilis and other sexually transmitted infections (STIs). ANC is also an opportunity to promote the use of skilled attendance at birth and healthy behaviors such as breastfeeding, early postnatal care, and planning for optimal pregnancy spacing.25

All 30 strategic health facilities provide ANC services, with the majority (26 out of the 30) having ANC clinics open five days a week, while the remaining run clinics between two and four days a week. Over the course of the project implementation, there were no reductions in the routine ANC services offered by health facilities from baseline to endline, improvements were noted at endline for urine tests for protein, hemoglobin tests, and screening for syphilis (Figure 4).

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2. Delivery services

Under the Tanzanian health care system, delivery services for pregnant women are usually available at all levels of care, with the prerequisite that medical essentials needed for the services are ensured. These include infrastructure with a delivery or labor room (if possible, with a post-natal ward/room), equipment including delivery bed, delivery kit, delivery table suction machines, ambu bag, warmers and sufficient light. The endline health facility survey used a standard checklist to assess whether the service was provided and the various essential requirements for the provision of the service were available.

Table 6 presents the number of all facility-based deliveries, which were recorded from all 30 strategic facilities at baseline (Jan-Dec 2014) and endline (Jan-Dec 2019).

Table 6: Number of all facility-based deliveries, at baseline (2014) and endline (2019)

<table>
<thead>
<tr>
<th>Facility Level</th>
<th>Total facility deliveries</th>
<th>Total facility deliveries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Jan – Dec 2014</td>
<td>Jan – Dec 2019</td>
</tr>
<tr>
<td>Total deliveries in dispensaries</td>
<td>2,088</td>
<td>1,880</td>
</tr>
<tr>
<td>Total deliveries in health centers</td>
<td>9,178</td>
<td>16,119</td>
</tr>
<tr>
<td>Total deliveries in all health facilities</td>
<td>11,266</td>
<td>17,999</td>
</tr>
</tbody>
</table>
Related to delivery services, the availability of delivery beds was found to be satisfactory. On average, facilities have three beds, with the number of beds ranging from two to eight across the 30 health facilities.

Privacy and confidentiality for patients, especially in the delivery room and or in the labor ward, are usually of paramount importance and a human rights matter. It was encouraging to find that all facilities provided privacy for the woman in the labor ward (i.e., women in the delivery room are protected from being seen by individuals she does not consent to through the use of partitions (curtains or bed screens); ), and women’s private information is not shared or heard by anyone without their consent.

The practice of skin-to-skin contact between the newborn and the mother is highly encouraged to develop the first bond between the mother and newborn. The Tanzanian Reproductive and Child Health guidelines emphasize and promote this practice to all pregnant women. All health facilities report implementing this practice, with most facilities implementing skin-to-skin contact for a period of 5 minutes to 60 minutes.

All facilities reported having a copy of the protocol on the management of Post-Partum Hemorrhage in the labor ward. The copy was physically observed at 26 out of the 30 health facilities. However, only 19 out of the 30 health facilities reported having a copy of the protocol on management of Ante-Partum Hemorrhage in the labor ward, and these were physically observed at six facilities.

3. Postpartum and postnatal care

In Tanzania, the Ministry of Health recommends that mothers and newborns receive a minimum of four Prenatal and Postpartum Care (PPC)/PNC consultations at the following times: within 48 hours of delivery, between three and seven days after delivery, and then between eight and 28 days and 29 to 42 days. The WHO estimates that if routine PPC/PNC and curative care in the postnatal period reaches 90% of newborns and their mothers, 10 to 27% of newborn deaths could be averted.

The UNICEF/KOICA project promoted the provision of quality PPC/PNC based on the above guidelines. At the endline, 28 out of the 30 health facilities reported monitoring women for up to 24 hours after normal delivery, while two facilities reported monitoring up to 48 hours. In Tanzania, and especially in facilities where bed capacity is limited, monitoring women up to 24 or 48 hours post-delivery is applicable in many circumstances depending on the mother and newborn’s conditions.

With respect to newborn care, 25 out of the 30 health facilities reported monitoring newborns for up to 24 hours following a normal delivery, and three facilities reported monitoring up to 48 hours after delivery. One facility reported seven hours, while another reported monitoring newborns for up to 72 hours. We did not explore the reasons for the time discrepancies as part of the endline survey. Apart from critical newborn health conditions that require additional care services, the differences in the amount of time newborns are monitored by the various facilities are expected to be corrected through training, mentorship, and supportive supervision.

To facilitate the provision of good quality PPC/PNC, the availability of appropriate infrastructure and essential equipment is necessary. The majority of the facilities (28) had a functional blood pressure machine in the PNC ward, and four facilities used digital blood pressure machines. Only four out of the 30 health facilities did not have beds in the PNC ward designated for PNC patients. The four facilities (Lubanda, Ukwavila, Ngonga and Njisi dispensaries) reported they did not have a PNC ward per se and used the beds in the reproductive child health section of the facility for observing mothers before discharge. The number of beds the PNC wards in the remaining 26 facilities had ranged from one to 12, and, on average, they had five beds. At least two health facilities reported having 12 beds (Isansa and Tunduma health centers).

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28 Charlotte Warren, Pat Daly, Lalla Toure, PyandeMongi. 2015. Opportunities for Africa’s Newborns.
Contribution of the project to establishing and improving the practice of KMC

The practice of KMC is another lifesaving intervention for saving the lives of premature babies or newborns with hypothermia. Tanzania has long adapted this intervention to be implemented in all district hospitals and hospitals with higher levels of care. Requirements for implementing KMC include the availability of trained personnel, a designated KMC room whenever possible, and the presence of appropriate KMC guidelines for reference.

As part of the UNICEF/KOICA project, KMC services were established through skilled-based training of HCWs and supportive clinical mentorship across all district hospitals and health facilities. KMC was planned to be scaled up to 10 district hospitals in the project area. According to the quarterly project report, by the time the project closed, a total of 14 hospitals, 12 of which were district hospitals and nine health centers in Mbeya and Songwe, were supported to establish KMC services. At endline, 19 out of the 30 health facilities reported providing KMC services, a significant increase from baseline, where only one facility, the Ruanda health center in Mbeya region, was providing KMC services following HCW training by USAID in the past. Furthermore, at endline, 11 out of the 19 health centers reported having the KMC guidelines and protocols.29 Thirteen out of the 19 health centers had a separate room designated for the KMC. In the three months before the survey, on average, eight new-borns received KMC services across the 18 out of the 19 facilities that provide KMC services, with the number of new-borns ranging from zero to 50.30

Contribution of the project to continued quality assurance for integrated RMNCAH services

Further to the infrastructure, equipment and HCW training, the project had a strong quality assurance and improvement component as part of its design. The project integrated its quality improvement initiatives alongside the existing quality improvement framework and initiatives that existed in the regions and the districts. Such initiatives include the establishment of quality improvement teams, supportive supervision, mentorship, and conducting maternal and perinatal death audits.

1. Integrated supportive supervision and mentorship

The project supported the two regions and 12 districts in their efforts to conduct regular supportive supervisions through training of supervisors on the national integrated supportive supervision guidelines for RMNCAH services and conduct of quarterly supportive supervisions at project health facilities. The project provided both technical support through training and accompanying supervisors to the quarterly visits and procuring a 4WD vehicle for regional supportive supervisions. The supportive supervisions were conducted by the respective CHMTs, which consisted of members trained through the UNICEF/KOICA project. The CHMT members monitored improvements in quality of care, uptake and practice of knowledge and skills received by HCWs, maintenance and use of essential equipment and supplies provided by the project and identified gaps in skills and quality of RMNCAH services delivered to inform further mentorship and support requirements. In addition to supporting visits to health facilities, UNICEF also provided, as part of this project, technical and financial support for the finalization of Tanzania’s RMNCAH Integrated Supportive Supervision guidelines which will contribute not only to improvement in the quality of care and accountability with respect to RMNCAH services in the target regions and districts but the country as a whole.31

At endline, only 21 out of the 30 strategic health facilities were able to provide supportive supervision logbooks to verify the number of visits undertaken by CHMT in 2019. As a result, our analysis will only focus on the 21 facilities so comparisons can be made between baseline and endline. The average number of

29 The interviewers were physically able to verify eight out of the 11 guidelines and protocols at these facilities.
30 Data on the number of newborns receiving KMC was only available for the 18 out of the 19 health facilities.
31 UNICEF Tanzania 1st, 2nd, 3rd and 4th Annual Report to KOICA.
CHMT visits conducted in 2014 and 2019 across the 21 facilities was higher at baseline (six visits, ranging from two to 12 visits), relative to endline (four visits, ranging from one to 13 visits). In 2019, two facilities (Ipinda and Ibaba health centers, reported receiving the highest number of visits at 12 and nine visits, respectively, whereas Lubanda Dispensary and Iyula health enter reported receiving only one visit. According to informal discussions with some CHMT members, the reasons why some facilities received more frequent visits relative to others are due to the proximity of the health facility; supervisors may at any time drop by when on their way to other facilities, and other emerging needs for frequent supervision due to performance of any other service and managerial activities. In the three months prior to the endline survey (between mid-November 2019 – mid-February 2020), all 21 health facilities received a supportive supervision visit from the CHMT.

2. Maternal and Perinatal Death Reviews

Through the UNICEF/KOICA project, the 12 districts across the two regions were able to conduct monthly MPDR meetings and implement follow-up actions from the review meetings. The project also provided technical and financial support in the development of national MPDSR guidelines and tools, printing and dissemination. Across the 30 strategic health facilities, the project trained and mentored facility staff to conduct regular MPDRs. At endline, all 30 health facilities reported conducting MPDRs; this is an increase from 14 facilities at baseline (Figure 5).

According to the national MPDSR guidelines, an MPDR should be conducted within seven days of a death at the health facility level. The frequency of MPDR has improved since baseline, with the majority of health facilities (19) conducting reviews within a week of the death occurring. However, some facilities (6) reported conducting the reviews monthly (3) or quarterly (8), which is not within the national guidelines (Figure 5).

Figure 5: Maternal and perinatal death reviews

<table>
<thead>
<tr>
<th>Frequency of MPDRs</th>
<th>Baseline</th>
<th>Endline</th>
</tr>
</thead>
<tbody>
<tr>
<td>MPDR conducted</td>
<td>14</td>
<td>30</td>
</tr>
<tr>
<td>Weekly</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>Monthly</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Quarterly</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

Base: Baseline n=14 and Endline n=30
Note: These findings are presented as reported by facility in-charge/service providers.

3. Quality Improvement Teams

Tanzania’s National Quality Improvement Framework stipulates the quality improvement teams (QIT) are responsible for training facility staff, conducting situation analysis and implementing quality improvement activities at the facility level, and conducting periodical monitoring and providing technical advice to work improvement teams (WITs). The QITs are expected to produce biannual progress reports to share with WIT, facility management teams, CHMT, and RHMT, depending on the level of the facility.

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The project supported the establishment of WITs across the 30 strategic health facilities to discuss and address gaps in the quality of services to improve the quality of maternal and newborn care services. The endline health facility survey did not capture whether each facility had a WIT, but rather only focused on QITs. The number of health facilities with QITs increased from 13 to 29 from baseline to endline (Figure 6). One facility, Lubanda Dispensary, reported they had not established a QIT as of yet, but is planning on setting this up in 2020/2021.

**Figure 6: Availability of quality improvement teams and frequency of meetings**

![Graph showing availability of QITs and frequency of meetings](image)

- **QIT available**: Baseline: 13, Endline: 29
- **Weekly**: Baseline: 6, Endline: 6
- **Monthly**: Baseline: 3, Endline: 21
- **Quarterly**: Baseline: 6, Endline: 2
- **Ad hoc**: Baseline: 0, Endline: 4

**Contribution of the project to improve and strengthen referral systems**

A strong referral system is characterized by a strategy informed by population needs and health system capacity; adequately resourced facilities; collaboration across referral levels and facilities; tailored referral protocols; provider support and accountability; formalized two-way communication and transportation systems between facilities; protections against costs of emergency referrals; capacity to monitor and system effectiveness; and government support. A strong referral system allows for the rational use of cost-effective health services along the entire continuum of care, improving health outcomes through improved access, efficiency, and equity to care. Access to ambulances for emergency referrals is limited across many of the target health facilities and the 12 districts. Only a third of the health facilities reported owning an ambulance, with the majority of health facilities depending on ambulances from nearby or referral facilities (Figure 7).

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The health facilities also reported several challenges that impaired the efficiency of the referral system (Figure 8). Forty-seven percent of health facilities lamented the lack of availability of ambulances or even other means of transport when they refer patients to the next level of care. Long distances from a referring facility to a receiving one, as well as difficulty in terrain, especially during the rainy season, were other factors cited. About 20% of health facilities mentioned, “other challenges,” and of these, the biggest issue was the delay in the arrival of the ambulance/vehicle from the moment it is called to the time it arrives.

To strengthen the existing referral system, the UNICEF/KOICA project procured and strategically distributed 11 ambulances across the target districts. The ambulances were distributed under the guidance of R/CHMTs, with the majority (10 out of 11) ambulances distributed to 10 of the 19 strategic health centers, the ambulance for Busokelo District Council was provided to Itete Designated Council Hospital – the only hospital at the time serving two health centers and 19 dispensaries in the council. The old Itete Hospital ambulance was assigned to the Mwakaleli CEmONC facility. One ambulance was provided to the Ndalambo health center in the Tunduma district because of the long distance to a referral facility. The ambulance donated to Ipinda health center in Kyela district council was involved in an accident in June 2018 and got written off.

**Outcome 2: Improved utilization of RMNCAH services**

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36 From the project background, these were some of the reasons for procurement and donation of ambulances at identified facilities. Reasons also include ease of in-referral and out-referral in facilities that were supported to become CEmONC sites.
In this section, we present the findings on how the UNICEF/KOICA project contributed to improved utilization of RMNCAH services in Mbeya and Songwe regions. We draw on quantitative data from the household survey and qualitative interviews at the community level, and, to some extent, at the facility level.

Table 7 presents a summary of the baseline and endline achievements for the outcome 2 indicators. Although some of the targets set at baseline are lower than the baseline values for some of the outcome indicators, we found the following changes at endline.

Table 7: Outcome 2 indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline (baseline report)</th>
<th>Baseline (matched)</th>
<th>Endline</th>
<th>Target (PDM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2a. % of mothers who attended four or more ANC for the most recent birth</td>
<td>62%</td>
<td>68%</td>
<td>86% ***</td>
<td>70%</td>
</tr>
<tr>
<td>2b. % of mothers who attended first ANC within 12 weeks for the most recent birth</td>
<td>47%</td>
<td>99%</td>
<td>56%</td>
<td>40%</td>
</tr>
<tr>
<td>2c. % of mothers who received IPT for the most recent birth</td>
<td>80%</td>
<td>70%</td>
<td>91% ***</td>
<td>90%</td>
</tr>
<tr>
<td>2d. % of live births attended by skilled personnel for the most recent birth</td>
<td>79%</td>
<td>83%</td>
<td>95% ***</td>
<td>70%</td>
</tr>
<tr>
<td>2e. % of mothers who received PNC within 48 hours for the most recent birth</td>
<td>14%</td>
<td>16%</td>
<td>19%</td>
<td>No target</td>
</tr>
<tr>
<td>2f. % of mothers-initiated breastfeeding within an hour for most recent childbirth</td>
<td>51%</td>
<td>58%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

***, **, *** represents statistical significance at the 10%, 5% and 1%, respectively

Utilization of ANC services

According to the focused antenatal care (FANC) model, a pregnant woman should attend her first ANC within four months of her pregnancy and undertake at least four ANC visits usually occurring between eight and 12 weeks of gestation, between 24 and 26 weeks, at 32 weeks and between 36 and 38 weeks.42

Through the FANC training provided to HCWs at the facility level and the community facility dialogues and community shows at the community level, the project aimed to increase awareness of women on when and

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37 The baseline value in the PDM was indicated as 44% for Mbeya rural and 53% for Mbarali, and the subsequent target was set at 70%. In the annual report the baseline value for this indicator was revised to 9.1%, which is likely an error and the target was reduced to 40%. For this evaluation, we have presented the baseline value per the baseline report and the original target indicated in the PDM document.

38 There are some issues of indicator statement, baseline value and target for Outcome 2 Indicator “% of mothers who attended first ANC within 12 weeks for the most recent birth” that affect the assessment of the achievement of target. This indicator was not included in the original project result matrix but added in the 1st and 2nd annual reports with baseline value (4.4%) and target (15%). In the 3rd and 4th annual reports, the indicator “% of mothers who attended first ANC within 16 weeks for the most recent birth” with the same baseline value (4.4%) and target (15%) was used instead. In the baseline report, the value for the indicator “% of mothers who attended first ANC within 12 weeks for the most recent birth” was reported as 47%, whereas further review of the baseline data as part of this evaluation finds the value to be 99%. The difference is attributed to errors in the syntax used for computing the indicator. However, it is highly unlikely that 99% of women in Tanzania would attend their first ANC within 12 weeks given the maternal health care situation in the country, and thus it is likely there were data cleaning or entry error in baseline assessment. As we are not able to verify the reasons behind why there is inconsistency between what has been presented in the baseline report versus the baseline data, we will only report on the end-line value for this indicator and not compare trends with the baseline. We present the baseline value per the baseline report, matched analysis undertaken at endline, endline value and the target set in the PDM in the table.

39 Due to a logical error in the electronic format of the endline survey, data on the number of IPT given to each woman that reported receiving IPT during her ANC visit for her most recent pregnancy was not gathered for the majority of the respondents. Hence, we have revised the indicator to report on the number of women who received IPT rather than those that received IPT at least twice. The baseline value for the original indicator, % of mothers who received IPT at least twice for the most recent birth, was 73%.

40 The wording of this indicator has changed from the original PDM, which stated “% of mothers who were attended by skilled health personnel at the most recent child birth” with baseline value of 43% and target of 70%, while the annual reports indicated % livebirths attended by skilled personnel in last five years, with baseline value of 78% and target of 80%. In addition, the target set in the PDM, does not align with the baseline value reported in the baseline report, i.e. it is lower than the baseline value.

41 The baseline value entered for this indicator was 92% in the UNICEF PDM; however, when cross-checking the baseline report and data, the value for this indicator is actually 14%. Therefore, the set target provided by the project was not based on accurate data.

why they should attend their ANC visits and increase the number of ANC visits attended by pregnant women in the project target areas.

At endline, over 90% of women reported they were aware that pregnant women should seek ANC within the first 12 weeks of their pregnancy (see Table 8). In practice, we found the proportion of women attending their first ANC visit within 12 weeks of their pregnancy was 56%.

**Pregnant women attending four or more ANC visits increased from baseline to endline.** We found the proportion of women who reported attending four or more ANC visits for their most recent birth saw a statistically significant increase from 68% at baseline to 86% at endline. This shows a positive improvement in the number of women seeking the required number of ANC visits or more during their pregnancy. Women’s level of satisfaction with ANC services received at the health facility during their most recent birth increased from 80% at baseline to 97% at endline. Some of the reasons cited for dissatisfaction at baseline were the use of abusive language and poor treatment by providers, poor or bad services, and the lack of drugs and supplies. The main areas of satisfaction cited by women at endline included the friendliness of health facility staff (68%), sufficient supply of drugs and supplies (31%), presence of qualified staff (22%), short or reasonable wait times (22%), availability of new equipment (14%), among others.

The number of health care services and procedures women received during their ANC visits showed a statistically significant increase from baseline to endline, with the exception of syphilis tests, urine screening, and measuring blood pressure (Figure 9). The proportion of mothers who received intermittent preventive treatment (IPT) during their most recent birth also showed a statistically significant increase, from 70% at baseline to 91% at endline. Similar increases were observed for HIV and hemoglobin testing and weight measurement.

**Figure 9: Procedures performed during ANC visit for the most recent birth**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Baseline</th>
<th>Endline</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV test</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Weight taken</td>
<td></td>
<td>63%</td>
</tr>
<tr>
<td>IPT to prevent malaria</td>
<td></td>
<td>71%</td>
</tr>
<tr>
<td>Hemoglobin test</td>
<td></td>
<td>67%</td>
</tr>
<tr>
<td>Urine taken</td>
<td></td>
<td>81%</td>
</tr>
<tr>
<td>Syphilis test</td>
<td></td>
<td>77%</td>
</tr>
<tr>
<td>Blood pressure measured</td>
<td></td>
<td>76%</td>
</tr>
</tbody>
</table>

Base: weighted data: Baseline n=2,286 and Endline n=1,366
* *, **, *** represents statistical significance at the 10%, 5% and 1%, respectively

**Contribution of Birth Preparedness Plan to increased utilization of ANC and delivery services**

According to the WHO, birth preparedness and complication readiness is an essential element of the ANC package where pregnant women are informed about the importance of having a BPP to be able to seek timely care in the event of any labor onset or complications.43 Through the training provided to healthcare

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workers and the development and distribution of IEC materials, the UNICEF-KOICA project aimed to increase the number of pregnant women, including adolescents developing BPP.

The number of women who developed BPPs during their most recent pregnancy showed a statistically significant increase from baseline (81%) to endline (94%). The proportion of adolescent girls (15-19 years) developing a BPP also increased from 79% to 89% from baseline to endline, although the change was not statistically significant. HCWs reported receiving training on BPP as part of the FANC training package offered by the UNICEF/KOICA project and utilizing the knowledge acquired to sensitize pregnant women and their partners/husbands or family members about the importance of having a BPP.

An HCW in the IDIs from Songwe stated: “There are things that they are required to prepare. The pregnant woman, for instance, is supposed to go for antenatal, for we educate groups, then individually, to her and her partner we educate them on things to prepare for before delivery, she should have five pairs of gloves, two razors, she is also supposed to have “vitenges” (a type of wrapping fabrics worn by women), five or more, a dish among others.”

In accordance to the WHO, a BPP should contain the following elements: the desired place of birth; the preferred birth attendant; the location of the closest facility for birth and in case of a complication; funds for any expenses related to birth and in case of complications; supplies and materials necessary to bring to the facility; an identified labor and birth companion; an identified support to look after the home and other children while the woman is away; transport to a facility for birth or in the case of a complication; and the identification of compatible blood donors in case of emergency.44

Among women who developed a BPP for their most recent pregnancy at endline, most women recall being advised on the supplies and materials necessary to bring to the facility for their delivery (98%) (Figure 10). Less than 20% of women reported the need to prepare money for transport when labor starts, prepare transport in case of an emergency, prepare money in case an operation is required, choosing a health facility and health professional to help deliver and prepare potential blood donors if needed. Although the consultation provided by HCWs on BPP normally covers all elements as per the WHO recommendation and the FANC training provided by the UNICEF/KOICA project, the majority of women placed more emphasis on the supplies and materials needed for delivery such as gloves, razors, pieces of mackintosh, and clothes for the baby and mother.

Figure 10: Awareness of the elements in BPP

<table>
<thead>
<tr>
<th>Supplies and materials to bring to the facility for delivery</th>
<th>98%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare money for transport when labor starts</td>
<td>22%</td>
</tr>
<tr>
<td>Prepare money for transport in case of emergency</td>
<td>17%</td>
</tr>
<tr>
<td>Prepare money in case of an operation</td>
<td>17%</td>
</tr>
<tr>
<td>Have a health professional who will help with delivery</td>
<td>2%</td>
</tr>
<tr>
<td>Choose health facility for delivery</td>
<td>6%</td>
</tr>
<tr>
<td>Prepare potential blood donors</td>
<td>5%</td>
</tr>
</tbody>
</table>

Base: Baseline n=1,134 and Endline n=1,283 (weighted data)
Note the data for baseline is pulled from the baseline report; therefore, the data is not weighted.

44 Ibid.
Similar responses were noted among women and adolescents in the FGDs; however, some respondents also emphasized other elements of the BPP such as the need to select a health facility to deliver, relocating closer to the health facility closer to the delivery date, or organizing for transportation from one’s home to the facility. Some participants also mentioned choosing someone to accompany them to the facility and saving money for food after delivery.

One woman in the FGDs in Mbarali stated: “You need to prepare or buy clothes for the expected child to ensure they are kept warm after delivery. One requires to have some money set aside to take care of all the needs for the newborn and food for the mother like soup, porridge, and others that will enable the mother to produce enough milk for the newborn baby. You will also need money for transport, and we are told to find someone to accompany you like your husband or mother-in-law. If you live far away, you are advised to move closer to the facility because labor pains may come at night.”

The majority of women (75%) at endline reported that, as part of their BPP, someone had encouraged them to deliver at the health facility for their most recent birth. Most women reported the nurse/midwives and doctors (81%) encouraged them to deliver at the health facility, followed by family members (29%) and traditional birth attendants (2%). Women in the FGDs reported that as a result of the BPP, they felt more prepared to seek delivery services at the health facility and were not apprehensive about being sent away or mistreated for not having all that is expected by the providers.

One woman from the FGDs in Kyela stated: “The nurses also advise that, as we near the due date, we should always have the preparation package with us...we can never know when the baby will come. So, in case the baby comes earlier than expected, I have all the necessary knickknacks required to receive the baby.”

Another woman from the FGDs in Kyela stated: “Yes... you prepare yourself in good time. It’s more manageable when you start early, and you collect the things over time.... it’s easier, financially.... you buy one thing at a time... [When you don’t have these items:] They [HCWs] chase you away… you are penalized… They tell you that they have educated you and told you over and over.”

Some women and adolescent girls in the FGDs and IDIs reported the messages received via the MnM service served as a reminder and also encouraged them to seek ANC and PNC services.

Utilization of delivery services

The number of live births delivered by a skilled birth attendant saw a statistically significant increase since baseline. The proportion of women who had a live birth for their most recent birth and was attended by a skilled birth attendant increased from 82% to 95% from baseline to endline, a statistically significant increase. In addition, the number of women delivering at the health facility for their most recent birth saw a statistically significant increase, from 77% to 91% from baseline to endline.

Women that did not deliver at the health facility at both baseline and endline either delivered at home or on the way to the facility.

Among women who reported delivering at the facility for their most recent birth, at endline, the main reason for deciding to deliver at the health facility was to ensure safe delivery (84%), followed by advice received by a nurse or doctor during their ANC visit (19%). Only 2% of women reported delivering at the health facility due to having a high-risk pregnancy.

About 92% of the women who delivered at the health facility at the endline stated they were satisfied with the care they received during their delivery for their most recent birth. This is an improvement from the baseline, where 84% of women reported being satisfied, although the difference is not statistically significant. Good customer care/hospitality and prompt service were stated as the main reasons for being satisfied with the care received during delivery (Figure 11). Of the small proportion of women who reported being dissatisfied...
with the services received (8%, 13 women), the main reasons cited were abusive language and harassment, delay in receiving care, and bad customer service.

**Figure 11: Satisfaction with delivery services**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good customer care/good hospitality</td>
<td>82%</td>
</tr>
<tr>
<td>No delay in receiving care</td>
<td>35%</td>
</tr>
<tr>
<td>Did not have to pay for drugs or supplies</td>
<td>22%</td>
</tr>
<tr>
<td>Adequate equipment or tests</td>
<td>21%</td>
</tr>
<tr>
<td>Adequate infrastructure</td>
<td>16%</td>
</tr>
<tr>
<td>Facility is close by</td>
<td>11%</td>
</tr>
<tr>
<td>No physical beatings</td>
<td>8%</td>
</tr>
<tr>
<td>No bad language and harassment</td>
<td>7%</td>
</tr>
</tbody>
</table>

Base: weighted data endline only n=1,013

**Utilization of PNC services**

**Women attending PNC within 48 hours of giving birth remained at less than 20%, despite a slight increase at endline.** At baseline, only 16% of the sample (i.e., women who gave birth at home and at the health facility for their most recent birth) reported attending PNC within 48 hours of giving birth; at endline, we found very little improvement, where only 19% of women received PNC within 48 hours. Among those that delivered at the health facility for their most recent pregnancy, 9% of women attended PNC within 48 hours of giving birth at baseline, which saw a statistically significant increase to 18% at endline. According to the health facility survey, all of the 30 strategic health facilities surveyed reported they advise women to attend follow-up PNC visits within 24-48 hours of giving birth. However, the data from the sample of women in the study implies this practice is not taken up by many.

**Generally, attendance at a PNC check post-delivery among new mothers in the sample saw a statistically significant decline from baseline to endline.** At baseline, 94% of the women reported attending a PNC check-up at the health facility following delivery, whereas at the endline, only 66% of women reported attending a PNC check-up for their most recent birth. About 33% of women at endline reported they did not attend a PNC check-up. The main reasons stated by women for not attending for PNC check-up were both the mother and baby were in good health, so they didn't see the need to go to the health facility (45%), while some reported they were not told by the health facility that they needed to return for a check (10%). Other reasons included having too many responsibilities in the household (1%) and, as a result, they could not find time to travel to the health facility, cost of transportation (7%), and charges at the health facility (6%).

Among the women who reported going to a PNC check-up following their most recent birth, most went three to seven days following delivery, at endline, relative to baseline, when most women attended one week after delivery. While the number of women attending a PNC within 48 hours of giving birth did not improve, the results show that relative to the baseline, more women are seeking PNC care within the first week of delivery (Figure 12).
In addition, the number of women attending repeated PNC visits within 40 days post-partum has increased significantly since the baseline. At the endline, we found that over 70% of women reported attending PNC more than once from the date of their delivery to 40 days postpartum, compared to 43% at baseline (Figure 13). More than half of the women at baseline attended PNC only once, which demonstrates that although many women do not attend PNC within 48 hours of giving birth, there were improvements in the number of PNC visits at endline relative to baseline. The results are statistically significant at the 1% level. In support of this trend, the qualitative data indicates that there has been an improvement in awareness creation around postpartum care. HCWs report that after being trained on MNCH services, they realized the importance of postpartum care for women, and they started sensitizing them about the recommended four repeat visits after delivery to check on their well-being. According to an HCW interviewed at one of the health facilities in Songwe: “The training has helped. For instance, women didn’t come for a postnatal check-up, and we, health workers, did not take it so seriously or know that there was a benefit of women coming for the postnatal check-up. However, after the training, women are coming for all the four visits. They come in, we do the check-up, and they are good to go.”

Figure 14 presents the type of counseling and other services received by women and their newborns during their PNC visit to the health facility.
Breastfeeding practices

Among women who reported breastfeeding their children, the proportion of women reporting breastfeeding immediately, i.e., within an hour of giving birth, increased from 58% at baseline to 80% at endline (Figure 15). Although this change is huge, the results are not statistically significant. The majority of women at both baseline (88%) and endline (92%) report not giving their newborn anything prior to breastfeeding, with slight improvement at endline. Similarly, the proportion of women who reported giving colostrum to their newborn saw a statistically significant increase from 82% to 99% from baseline to endline at the 1% level.

HCWs stated that awareness creation around breastfeeding practices at the health facility level has helped empower first-time mothers through education on immediate initiation of suckling, proper latching onto the breast, how to tell if the baby is feeding well by the sounds they make and exclusive breastfeeding for the first six months of the baby’s life. Additionally, women and adolescents also mentioned getting information about exclusive breastfeeding from MnM services and the radio. While these results might be attributable to the variety of health education campaigns through various channels, it is likely that a contributing factor is a change in HCWs attitudes resulting from the embedded training they received to counsel women who deliver in a health facility to initiate breastfeeding within an hour of giving birth.

According to an HCW interviewed at one of the health facilities in Kyela: “The trainings have been very beneficial... For example, in postnatal care, you can find that you have safely delivered a baby, and the
mother is a first-timer who doesn’t know how to breastfeed. A mother should start breastfeeding immediately when the child is born… that mother needs training so that she can know what to do. So they learn how to breastfeed on time…by the time they come back after seven days the child is healthy.”

The involvement of men in the sensitization activities on proper child nutrition ensured women have moral and financial support, with men reporting that they make sure that their spouses get proper nutrition so they can produce enough and nutritious milk for the baby. The sensitization was also done using different channels, including mass media, facility dialogues, and counseling at PNC clinics, which guaranteed a wider reach of different target groups. The women also reported that introducing babies to other foods before the recommended time could result in the baby suffering from malnutrition, which could result in stunting. However, a few of the community respondents noted that due to poverty and lack of finances, they are unable to provide their spouses with sufficient food, which they believe impacts the amount of milk the woman produces, and thus they end up introducing food to the baby before the six months.

**Outcome 3: Improved community awareness and demand for quality RMNCAH service**

To improve community awareness and demand for quality RMNCAH services, the UNICEF/KOICA project implemented HCW training on MnM, facility and community dialogues, and radio and other communication campaigns. We drew on quantitative data from the household survey and qualitative interviews at the community and health facility level.

Table 8 presents the baseline and endline achievements for the outcome 3 indicators. The project achieved the targets for all indicators under outcome 3. All changes from baseline to endline are statistically significant, with the exception of indicator 3d for which a statistical significance test was not performed. The baseline values for all outcome 3 indicators are presented in two forms, (i) based on what was reported in the baseline report and (ii) using the final matched dataset with the endline sample. Although the results are not identical, the results are not too far off from each other.

**Table 8: Outcome 3 indicators**

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Baseline (baseline report)</th>
<th>Baseline (matched)</th>
<th>Endline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>3a. % of women of childbearing age (WCBA) willing to deliver next child at the health facility</td>
<td>98%</td>
<td>85%</td>
<td>100% ***</td>
<td>100%</td>
</tr>
<tr>
<td>3b.(i) % of mothers-in-law willing to allow daughters-in-law to deliver at the health facility</td>
<td>MIL: 97%</td>
<td>MIL: 95%</td>
<td>MIL:100% ***</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>3b.(ii) % of fathers-in-law willing to allow daughters-in-law to deliver at the health facility</td>
<td>FIL:97%</td>
<td>FIL: 96%</td>
<td>FIL: 100% ***</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>3c. % of WCBA willing to visit the health facility for ANC for their next pregnancy</td>
<td>98%</td>
<td>91%</td>
<td>99% ***</td>
<td>100%</td>
</tr>
<tr>
<td>3d. % of WCBA who are aware that pregnant women should seek ANC within 12 weeks of their pregnancy</td>
<td>83%</td>
<td>99%</td>
<td>94%</td>
<td>No target</td>
</tr>
</tbody>
</table>

45 The target for this indicator was set based on the value reported in the baseline report, which was 83%. Further review of the baseline data finds the actual value for this indicator at baseline was 99%.

46 This indicator has been revised to within 12 weeks, in the original PDM and subsequent annual reports the indicator was before 16 weeks. The target for this indicator in the annual reports was based on “% of WCBA who are aware that pregnant women should seek ANC within 16 weeks of their pregnancy”, therefore, based on the revised wording the target for this indicator was not originally set.
There is high awareness among women as to when they should seek their first ANC visit. Most women across both baseline (99%) and endline (94%) were aware that a pregnant woman should seek her first ANC visit within 12 weeks of her pregnancy (Table 8). Although there is a slight decline from the baseline, the change is not statistically significant. Respondents in the community-level FGDs and IDIs stated awareness creation activities at the health facility via HCWs, community dialogues, and door-to-door visits had contributed to their increased awareness around the benefits of seeking early ANC for the mother and their unborn child. Respondents also noted the importance of attending ANC visits as early as 12 weeks because it would lead to early detection of conditions such as anemia and high blood pressure, which are detrimental to both mother and child.

Knowledge and awareness of the danger signs during pregnancy, childbirth, and post-delivery, from baseline to endline, have also shown a statistically significant improvement among women in the sample, as shown in Table 9. More than three-quarters of women reported being advised during their ANC visit on the danger signs that require a pregnant woman to seek care. This is a substantial improvement from the baseline, where only 55% of women reported being counseled on the danger signs relative to 76% at endline. Figure 16 presents the type of topics women were counseled on during their ANC visit for most recent birth.

Table 9: Knowledge of danger signs during pregnancy, childbirth, and post-delivery

<table>
<thead>
<tr>
<th>Knowledge of dangers signs during pregnancy***</th>
<th>Baseline</th>
<th>Endline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal bleeding</td>
<td>35%</td>
<td>87%</td>
</tr>
<tr>
<td>Reduced/cessation of fetal movements</td>
<td>10%</td>
<td>74%</td>
</tr>
<tr>
<td>Swollen hands/legs</td>
<td>6%</td>
<td>65%</td>
</tr>
<tr>
<td>Severe headache</td>
<td>14%</td>
<td>72%</td>
</tr>
<tr>
<td>Blurred vision</td>
<td>11%</td>
<td>46%</td>
</tr>
<tr>
<td>Fits/convulsions</td>
<td>5%</td>
<td>37%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Knowledge of danger signs during childbirth***</th>
<th>Baseline</th>
<th>Endline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe vaginal bleeding</td>
<td>36%</td>
<td>76%</td>
</tr>
<tr>
<td>Foul-smelling vaginal discharge</td>
<td>0%</td>
<td>67%</td>
</tr>
<tr>
<td>High fever</td>
<td>0%</td>
<td>69%</td>
</tr>
<tr>
<td>Fits/convulsions</td>
<td>7%</td>
<td>48%</td>
</tr>
</tbody>
</table>

Figure 16: Topics women were counseled on during their ANC for most recent birth
Base: weighted data, Endline n=1,366

There is high awareness around RMNCAH
<table>
<thead>
<tr>
<th>Score</th>
<th>Baseline</th>
<th>Endline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe vaginal bleeding</td>
<td>34%</td>
<td>73%</td>
</tr>
<tr>
<td>Foul-smelling vaginal discharge</td>
<td>0%</td>
<td>64%</td>
</tr>
<tr>
<td>Fits/convulsions</td>
<td>0%</td>
<td>45%</td>
</tr>
<tr>
<td>High fever</td>
<td>12%</td>
<td>54%</td>
</tr>
</tbody>
</table>

Base: weighted data
Knowledge of danger signs during pregnancy: Baseline n=2,498 and Endline n=1,571
Knowledge of danger signs during childbirth: Baseline n=2,530 and Endline n=1,571
Knowledge of danger signs after birth: Baseline n=2,532 and Endline n=1,366
*, **, *** represents statistical significance at the 10%, 5% and 1%, respectively

Furthermore, qualitative respondents in the FGDs and IDIs at the community level were able to recite the different dangers signs that women should look out for during their pregnancy, childbirth, and post-delivery. Some of the signs cited included severe headaches, high blood pressure, vaginal bleeding, any foul-smelling vaginal discharge, swollen limbs, an absence of or reduced fetal movement, blurred vision, and convulsions. They attributed this to the information provided to them during the facility dialogues and counseling sessions held during the ANC clinics. HCWs also reported undertaking counseling sessions with pregnant women around danger signs and also tailored counseling to the women’s particular health situation. The project activities at the health facility and community levels through the training of HCWs, community-facility dialogues, radio programs, print media, and MnM has contributed to increased knowledge and awareness among women, adolescents, men and others within the community on the danger signs during pregnancy, childbirth and post-delivery.

One male respondent in the FGDs in Mbozi noted: “There has been a reduction in neonatal deaths.... there are posters advising expectant mothers to get to a health facility as soon as they experience certain symptoms... This is different from the past where when someone experiencing a discomfort would go to a traditional healer who would give them a concoction of herbs... During that time that education was lacking, there were many neonatal deaths... But currently, under the KOICA/UNICEF initiative, we can get information from the facility.... others are getting information through their phones, thus reducing neonatal deaths.”

In addition to increased knowledge of the danger signs around pregnancy, women have increased awareness of the type of RMNCH services available to them at their nearest health facility. Figure 17 presents the level of awareness of women on the types of RMNCH services provided by the health facility nearest to their homes, from baseline to endline. The top two services noted were vaccination and ANC services, followed by delivery and family planning services. The majority of women had utilized one or more of these services in the past three years prior to the survey (between 2015-2019).

Figure 17: Awareness of RMNCH services and services utilized in the past three years (2017-2019)
The majority of the health facilities cited by women in the endline sample that provide RMNCH services closest to their home were the health facilities (both the strategic health facilities and the dispensaries) targeted by the UNICEF/KOICA project. To understand the quality of the RMNCAH services offered and any improvements in services over the past three years (2017-2019) prior to the survey, we asked women in the endline sample if they noticed any changes to the quality of services offered. **About 69% of women reported noticing some form of change, either positive or negative, or both. The remaining 31% reported no change.** Among those who reported noticing a positive improvement in the quality of services, the key areas of improvement were health facility staff were more friendly (47%), reduction in wait times (32%) and refurbishments and renovations (19%) (Figure 18).

**Figure 18: Positive changes in the quality of services at the nearest RMNCH health facility (2017-2019)**

- Friendly staff: 47%
- Reduced wait times: 32%
- Refurbishments or renovation of health facilities: 19%
- Improvements in AFRH services: 15%
- Establishment of AFRH services: 13%
- HCWs helping pregnant women develop BPP: 12%
- Improvements in equipment to support delivery and after childbirth care: 9%
- Availability of more ambulances: 7%
- MnM services: 9%

Base: weighted data for Endline only n=919

Among those who reported negative changes, lack of AFRH services and friendly HCWs were the major concerns, as shown in Figure 19. Some women believe HCWs are not friendly because they overworked
and the lack of available equipment and training to do their jobs properly. The support provided by the project has contributed to some of the positive changes noted by participants in the study.

Figure 19: Negative changes in the quality of service at the nearest RMNCH health facility (2017-2019)

- Less friendly staff: 43%
- Lack of AFRH services: 51%
- Increased wait times: 23%
- Operating theaters are of poor quality: 14%
- No operating theatres: 14%
- Lack of toilets: 13%
- Lack of equipments to support delivery…: 3%
- HCWa don’t help pregnant women…: 2%
- Dirty toilets: 1%

Base: weighted data for Endline only n=290

The intention of women of childbearing age (WCBA) to visit the health facility for ANC, delivery, and PNC during the next pregnancy

Among the women in the sample who report wanting to have more children in the future (69% at baseline and 78% at endline), the proportion of women who expressed willingness or the intention to visit the health facility for ANC and delivery, saw a statistically significant increase from baseline to endline, while those willing to visit the health facility for PNC declined (Figure 20).

Figure 20: Percentage of women of child-bearing age (WCBA) willing to visit the health facility for ANC, delivery, and PNC for next pregnancy

- **Willing to deliver at the health facility during next pregnancy***: 85% (Baseline) to 100% (Endline)
- **Willing to visit ANC for next pregnancy***: 91% (Baseline) to 99% (Endline)
- **Willing to visit PNC for next pregnancy**: 93% (Baseline) to 78% (Endline)

Base: weight data: First indicator (baseline n=2,445 and endline n=1,262) and second indicator (baseline n=2,350 and endline n=1,274) and third indicator (baseline n=2,410 and endline n=1,215)

*, **, *** represents statistical significance at the 10%, 5% and 1%

- **ANC**: Over 90% of women expressed their willingness to visit ANC during their next pregnancy at both baseline (91%) and endline (99%) (Figure 20). The top two reasons for seeking ANC care during the next pregnancy was to know more about my and my child’s health (33%) and in case of complications (23%) (Figure 21).
- **Delivery**: There was a statistically significant increase in the proportion of women who reported they plan to deliver at the health facility for their next pregnancy, increasing from 85% to 100% from baseline to endline, respectively (Figure 20). The main reasons cited by women wanting to deliver at the health facility in the future were good customer care (51%), the facility being close by (32%), and no delay in receiving care (24%) (Figure 21).

- **PNC**: The proportion of WCBA willing to visit the health facility for PNC following the delivery of their next child, showed a statistically significant decline from baseline to endline, from 93% to 78% (Figure 20). Among those that reported their intention to visit a facility, the top two reasons cited were good customer care/hospitality (27%) and in case of any complications (18%) (Figure 21). Among the women who reported they did not plan to attend PNC at the health facility in the future, the top reasons cited were poor infrastructure and distance to the facility. A much lower percentage of women reported delays in receiving care, abusive language, and harassment, or inadequate equipment or tests.

Figure 21: Reason for wanting to visit the health facility for ANC, delivery and PNC services during next pregnancy

![Reasons for visiting health facility](image)

Base: weighted data for Endline only

**Views of husband/partner, mother-in-law and father-in-law on pregnant women attending ANC and delivering at the health facility**

Women feel that their husband/partner and their father/mother-in-law believe that attending ANC visits and delivering at the health facility is essential for pregnant women (Figure 22).

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Figure 22: Women’s perception on how their husband/partner, mother-in-law and father-in-law view pregnant women attending ANC and delivering at the health facility

<table>
<thead>
<tr>
<th></th>
<th>Husband/partner</th>
<th>Mother-in-law</th>
<th>Father-in-law</th>
</tr>
</thead>
<tbody>
<tr>
<td>Essential for pregnant woman to attend ANC***</td>
<td>99% 100%</td>
<td>95% 100%</td>
<td>97% 100%</td>
</tr>
<tr>
<td>Essential for pregnant woman to deliver at the health facility***</td>
<td>96% 100%</td>
<td>98% 100%</td>
<td>96% 100%</td>
</tr>
</tbody>
</table>
| Base: weighted data: Husband/partner (Baseline n=1,984 and Endline n=1,381); mother-in-law (Baseline n=1,202 and Endline n=927); and father-in-law (Baseline n=1,160 and Endline n=569)
*; **, *** represents statistical significance at the 10%, 5% and 1%, respectively

- **Husband/partner view:** Women reported they feel that their husband/partner believes that ANC and delivery at the health facility are essential, both at baseline and endline. Across baseline and endline, 99% of women reported their husbands or partner attending the ANC visit with them during their most recent pregnancy. Most women believe their husband or partner cannot deny or prevent them from giving birth at the health facility, and the decision is theirs. Women in the qualitative interview report that their husbands provide them with moral and financial support and even accompany them for the ANC visit. The men in the FGDs also reported that they offer to help their partner with the household and farm chores so that they can get time to visit the facility on their clinic day. For women who registered for the MnM service via their husband’s mobile phone number, the male respondents in the FGDs report that when they receive the SMS reminders, they also inform and encourage their wives/spouses to attend their ANC and PNC visit at the health facility.

- **Mother-in-law view:** At baseline, about 91% of women reported their mother-in-law could not deny or prevent them from giving birth at the health facility, while about 9% reported she could. At the endline, we found that 100% of the women reported they believe their mother-in-law cannot deny them from giving birth at the health facility, which is an improvement and a statistically significant change at the 1%. Most women noted that their mother-in-law is crucial to supporting them during their pregnancy by accompanying them to the health facility (74%), supporting household chores (40%), supporting during labor (25%), and watching over the other children (21%). Other support functions also include encouraging women to attend ANC visits and supporting them with transport money. Only about 10% of women reported influencing their husbands to allow them to deliver at the health facility.

- **Father-in-law view:** Similarly to the views of the mother-in-law, most women reported positive views from their father-in-law in terms of visiting the health facility for the ANC and delivery services. At baseline, about 10% of women reported their father-in-law could deny or prevent them from delivering at the health facility. However, at the endline, the views on this showed similar changes to that of the mother-in-law, where all women reported they feel their father-in-law cannot deny or prevent them from delivering at the health facility, and these changes are statistically significant at the 1% level. In terms of the type of support the woman feels she can get from her father-in-law, women cited accompanying them to the health facility (50%) and influencing their husband to allow
them to deliver at the health facility (47%). Other support functions include paying for transport (10%) and watching over the children (3%).

Grandmothers and mothers-in-law in the IDIs reported being educated on the importance of seeking RMNCAH care at the health facility via HCWs and through the community-facility dialogues. As a result, they motivate and educate their daughters, daughters-in-law, and granddaughters around RMNCAH, and accompany them to the health facility or watch over the children while they attend their clinic visits.

Contribution of MnM services on providing timely feedback about the RMNCAH services and reminders for PNC and ANC visits

MnM services provide reminders and encourage pregnant and lactating women to attend ANC and PNC visits. Pregnant and lactating women were encouraged to register (via their mobile phone) for the MnM service at the health facility during the ANC and PNC clinic visits. In addition to reminders, the purpose of the MnM service is to give pregnant and lactating women a mechanism for providing feedback on the services received. Awareness of MnM among women in the endline sample was relatively low, with only 42% of women reporting having heard about the service. Among the women who reported being aware of the service, about 40% signed up for the service. Women who did not sign up for the service noted factors such as not having a cell phone (28%), not understanding the service (23%), their husbands not allowing them (11%), and others didn’t see the value in the service or forgot to sign up (44%).

Most women reported using the service to provide feedback on the service they received at the health facility (44%), while others reported receiving reminders for ANC (19%) and PNC (18%) visits depending on where they were in the pregnancy or post-delivery. Women who reported receiving the ANC and PNC reminders said they helped encourage them to go to the health facility for their ANC and PNC check-ups. Slightly less than a fifth of women reported signing up for the service; however, since they did not own their own phone, they could not engage with the service as much (Figure 23).

One grandmother in the IDIs from Mbozi stated:
“The government has sensitized the community, and everybody goes to the health facility when pregnant. When you discover you are pregnant, you ought to go to the clinic to get tested and get an appointment card. It doesn’t matter even at one or two months pregnant you ought to go and get checked at the clinic. The only time a woman delivers away from the hospital is when it’s an emergency, and she’s being rushed to the hospital, and the child comes before they reach the hospital.”

One key informant from HMT in Mbarali stated: “Mama na Mwana helped with the awareness creation amongst the expectant mothers and those with young children... It has also increased the number of mothers coming for services at the facility. The mothers are made aware of what they need to do. Even for the providers, it’s easier to identify when and where there is a problem depending on their responses.”

![Figure 23: Use of MnM services](image-url)

Base: Weighted data for Endline only n=234 service noted factors such as not having a cell phone (28%), not understanding the service (23%), their husbands not allowing them (11%), and others didn’t see the value in the service or forgot to sign up (44%).
The awareness level of MnM services among adolescents was extremely low, at 10%, with only about 29% of adolescent girls (13 girls) signing up for the service. All of the girls who signed up for the service had their own phone and used it mainly to provide feedback on the service and to get ANC and PNC reminders. The main reasons for the low uptake among adolescent girls were lack of phone ownership and not understanding the service. Adolescent girls in the qualitative IDIs who signed up to the service reported liking the service because it provides them with a more personalized message regarding their pregnancy and is a private medium, and that not even their parents would know if they received messages on RMNCAH services. One drawback to the service was the lack of interaction (i.e., most adolescents would have liked to be able to ask questions and receive feedback).

An adolescent in Mbarali stated: “When I went to register for a card, that’s when I noted my number, and they started sending the messages at least every month saying the progress of your pregnancy. The certain month you eat certain foods stuff, that’s what they send. I like it is private and personal, but then you cannot ask a question and get a response.”

3.2.2 What were the factors that facilitated or inhibited the achievement of the project’s objectives and expected results?

Facilitators

- **Putting in place accountability measures for disbursement of funds to enforce timeliness and quality.** To ensure refurbishments and renovation activities were timely and of high quality, UNICEF set up timelines and expected outputs for each quarter before disbursing additional funds. UNICEF also contracted an engineer who worked closely with the district engineers to perform quality checks of all the construction sites in a timely manner.

- **The use of a sector-wide approach enhanced interdepartmental collaboration at the council level.** The interdepartmental collaboration between the diverse departments such as water and sanitation, energy, and public works, in conjunction with the health department, whose role was to oversee the activities acted as a facilitator, helped to make this project successful. Cooperation among these departments ensured that each did their part in the construction process and in the preparation of reconciliation reports for liquidation. It also enabled the timely provision of services such as connection to piped water, sewerage systems, and the national electricity grid, which ensured that buildings, especially those meant for CEmONC services, were fully functional.

- **The role of the Health Facility Governing Committees was fundamental in creating buy-in and ownership of the project.** The involvement of the community health committees at the facility level resulted in project ownership by the locals, and some involved themselves in facilitating the process by providing labor and locally available construction materials such as sand, stones and burnt clay bricks.

- **Centralized procurement of equipment by UNICEF reduced delays and ensured quality.** All equipment procured under this project was deemed to be of high quality, and the distributors hired by UNICEF were able to make timely deliveries either directly to the facilities or through the regional and district offices, minimizing any kind of logistical delays.

- **Well-coordinated and well-delivered on-the-job-training enabled the effective capacity building of HCWs.** This was implemented by contracting TTCIH- Ifakara and LSTM to offer quality training on task shifting for C-sections and EmONC, and quality improvement and MPDSR at the facility level. Training on integrated supportive supervision, AFRH services, and other maternal and newborn packages (ANC,
PNC, B/CEmONC, essential newborn care, KMC, and MPDSR), which were facilitated by MOHCDGEC and R/CHMTs added to the achievements of the project objectives.

- **The MPDSR intervention facilitated open and constructive discussion on death audits.** This intervention involved orienting R/CHMTs around updated national MPDSR guidelines, conducting of MPDSR meetings quarterly at the regional level, and monthly at the council level, maternal and perinatal death audits at health facilities, and development of action plans and their follow-up to ensure prevention of similar maternal/perinatal deaths in the future. The experience and learning from these activities were also integrated into UNICEF’s support to the MOHCDGEC for developing and disseminating MPDSR and integrated RMNCAH supportive supervision guidelines at the national level.

- **District councils’ initiatives to respond to staff turnover helped to maintain imparted knowledge.** Some of the project facilities faced a shortage of staff; thus, to rectify this, the recruitment of new staff and redeployment of current staff to facilities that were in need was done. For example, redeployment of an anesthetist from Mbarali District Hospital to Utengule Usangu allowed the health center to start offering the much-needed CEmONC services.

- **Innovation, harnessing benefits of partnerships, and responding to context-specific realities were key to success.** The program introduced interactive community dialogue platforms to increase the volume of feedback from lactating and pregnant women on the quality of services at health facilities. This innovation provided the platform on which feedback was then used to improve service provision in the project facilities.

- **The contribution of external outreach services augmented project efforts.** Provision of outreach services by other partner NGOs such as GIZ and Marie Stopes at the village level for different RMNCAH services led to increased utilization of services such as vaccination and dispensing of antiretrovirals and family planning.

### Inhibitors

- **Government bureaucracy:** During the planning phase for facility refurbishments and renovations, the project experienced delays due to government bureaucracy in the procurement process, which, in the end, resulted in delays in the completion of some of the planned works against the original project work plan.

- **Interpersonal factors:** Personality clashes between some of the district engineers and some of the District Medical Officers, as well as between district engineers and the contractors, were reported to have an impact on the quality of the finished buildings or delays in the completion of work in some of the facilities.

- **Policy-related factors:** The government, during the project implementation, issued upgraded design guidelines and standards for health centers that met the requirements for CEmONC status, including the number of buildings that were needed (operating theatres, maternity wards, outpatient, laboratory buildings, staff houses, etc.). Some of the facilities identified for CEmONC upgrading by the UNICEF/KOICA project were also later identified by the government for the same purpose. This resulted in buildings renovated by the project in two facilities, Mbuyuni and Ibaba health centers, to serve as operating theatres to be put to other uses, which delayed their use for C-section services. The new buildings constructed through government funding are in advanced stage of completion in both facilities and Songwe RHMT reports they will be ready to provide C-section services by July 2020.

- **Health system factors:** Other factors outside of the control of the project, including weak supply-chain systems leading to stockouts of drugs, vaccines, and other commodities, staff turnover resulting in staff shortages, lack of separate rooms for exclusive AFRH service, lack of knowledge on equipment
maintenance were barriers to the achievement of the key outcomes and expected results during project implementation and are likely to continue to be barriers in the future.

- **Socio-cultural factors**: The lack of moral and social support for pregnant women is an impediment to their seeking RMNCAH services. Single women and adolescents who are neglected by their families and boyfriends were reported to be the most susceptible to this challenge. Poverty among the target beneficiaries was also reported as an inhibitor to seeking RMNCAH services and to the uptake of recommended nutrition for pregnant and lactating women and children under five.

- **Remoteness and geographical inaccessibility of some facilities**: The poor road network in Mbeya and Songwe regions was reported by the majority of the respondents as an inhibitor to seeking RMNCAH services. Consequently, sometimes it results in the loss of life due to delayed access to emergency obstetric services. Although the procurement and distribution of 11 ambulances intended to solve this challenge, the long distances to health facilities, aggravated by poor road conditions was reported to inhibit the prompt service provision needed to save the lives of women and children.

### 3.2.3 Which project activities contributed most significantly to the key outcomes?

Based on the perceptions of the different stakeholders, the evaluation assessed which project activities played the biggest role in achieving the key outcomes. The responses stakeholders provided at the national, sub-national, health facility, and community level varied. Some of the key activities noted were:

- **Building the technical capacity of healthcare workers**: HCWs felt that with proper training received, the renovated/refurbished buildings and donated equipment are being put to proper use resulting in availability and readiness of quality RMNCAH services. The provision of equipment, although a separate activity, was linked to the training because the equipment was used in the practical sessions. Specifically, EmONC training on resuscitation of neonates, administration of anesthesia, conducting obstetric surgery (C-section), and KMC have been significant in saving the lives of mothers and their newborn children.

- **Procurement of ambulances for emergency obstetric referrals**: Stakeholders from the sub-national government felt the ambulances had made an impact on the reduction of maternal and neonatal deaths by ensuring that those who need critical EmONC services are referred to a suitable referral facility in good time. At the same time, the community level respondents and the key respondents agreed that a gap still exists in emergency referral services as the number of ambulances are not adequate in relation to the population and geographical size of the regions.

- **Community and facility dialogues**: The majority of the project beneficiaries reiterated how the advice they received from an IPC session with HCWs either at the facility or in the community made them adopt the desired behavior of seeking RMNCAH services. Furthermore, counseling sessions during service delivery also had a positive effect on women’s and adolescents’ intentions on the repeated use of RMNCAH services. This activity was also relevant to those who did not have access to a phone or radio, and the illiterate.

### 3.2.4 How effective have the M&E framework/components of the project been at assessing results?

**How well was the M&E framework designed to allow the project to measure and assess the performance of the projects?**

As part of the project design and proposal, UNICEF developed a clear plan for M&E of the project against the logical framework. The M&E plan laid out the steps for undertaking participatory M&E exercises at different stages of the project. This included undertaking a baseline and endline study at the beginning and
end of the project, respectively, across all 12 districts to measure the key outcomes of the project. In addition to a midterm project review conducted halfway through project implementation, UNICEF led regular project performance monitoring through its sub-national office in Iringa and later its Mbeya office, and provided support on the implementation of planned activities, reports, supplies and other related tasks. In addition, UNICEF also planned and conducted joint monitoring and learning field visits at least twice a year with KOICA, local government and other key partners in MNCH. Lastly, UNICEF conducted periodic financial spot checks in accordance with the HACT guidelines.

The project results framework was designed in line with the project theory of change outlining three main outcomes and the respective outputs and activities. Indicators at each of the three levels were properly defined with respective targets set based on baseline values at the beginning of the project. However, there were some inconsistencies in the indicators used across the project lifetime and, in some cases, incorrect baseline values were observed:

- **Inconsistent indicator definitions**: For example, outcome indicator 2b, % mothers who attended first ANC before 12 weeks for most recent childbirth did not exist in the original results framework but was then later added to the 1st and 2nd annual reports. Then in the 3rd and 4th annual reports, this indicator was revised to % mothers who attended first ANC before 16 weeks for most recent childbirth—and adjusted back to before 12 weeks for this evaluation. Other similar cases were noted for other indicators under outcome 1 and 3. See Annex J, for comparison of the indicators over the course of the project.

- **Incorrect baseline values**: Baseline values for some indicators were incorrect and this had implications on the targets set. For instance, for indicator 2e under outcome 2, the baseline value was indicated as 92% in the results framework and the target was set to >90% at endline. Following the reanalysis of the baseline data, the correct baseline value was 14%, thus making the target of >90% unrealistic for the project to achieve in the project lifetime. See Annex J for other indicators with similar issues.

**Monitoring and evaluation activities undertaken by the project**

- **Baseline study**: A baseline study was commissioned and conducted in 2014/2015 across all of the 12 districts before the program implementation started. The study used mixed-methods which included both primary quantitative and qualitative data collection. The quantitative component included a detailed health facility survey conducted across all 30 strategic health facilities and 11 district and mission hospitals. A household survey was also conducted in 99 villages across the 12 districts, followed by qualitative interviews at the community level. The data from the baseline study was used to establish baseline values for the outcome level indicators and also to assess the existing capacity of health facilities to provide quality RMNACH services and barriers that women face in seeking and accessing care early in their pregnancy and post-delivery.

- **Midterm review**: Two years into the project (2017), a midterm review was conducted with the participation of KOICA. This did not involve any new data collection but included a review of the progress of results based on the existing data, such as HMIS and monitoring reports, as well as consultations and interviews with key stakeholders.

- **Regular monitoring**: Regular monitoring of the performance of the project was initially led by UNICEF’s field office in Iringa, which coordinated and oversaw programs supported by UNICEF in the southern highland regions, including Mbeya. In January 2017, UNICEF opened a field office in Mbeya. The UNICEF team made regular visits to health facilities, monitoring and providing support on the implementation of planned activities, monitoring supplies, verifying reports, and documents on key findings. UNICEF health program staff based at the head office in Dar es Salaam conducted
technical support visits and monitoring of supported program activities each quarter, including facility renovation. Additional technical support and monitoring was initially undertaken by a maternal and child health consultant, and, later, a health program specialist stationed in Mbeya so that closer follow-up and on-the-job training of facility-based staff with specific site visits could be facilitated. UNICEF health program staff conducted their annual retreat in Mbeya in November 2017, which included field visits to some selected project supported facilities. UNICEF followed up on the delivery and distribution of equipment and IEC materials to health facilities and the community, and regularly communicated via phone and emails with the regional and district authorities regarding the implementation of supported activities and reporting.

- **Joint monitoring and learning field visits:** UNICEF funded and organized biannual joint monitoring and learning field visits with KOICA, the local government counterparts, and other key partners supporting MNCH services to enhance capacity building and project ownership by the local authority.

- **Financial spot checks:** UNICEF conducted financial spot checks in accordance with the guideline of the HACT. This included the development of periodic assurance plans and financial spot checks of implementing partners. Consulting engineers were hired and worked closely with the UNICEF M&E team at the sub-national level to run quality checks on the bill of quantities, building plans, and the constructions in every project district.

- **Endline evaluation:** At the end of the project, an endline evaluation was commissioned to assess whether the project had achieved the outcomes as per its theory of change and results framework.

**In what ways did the project use the ongoing monitoring data and the midterm review to inform the design, implementation, and decision-making throughout the project implementation?**

**Midterm review**

The midterm review included a review of the project progress and assessed whether the project was likely to achieve its outputs within the planned timeframe. The midterm review found that the progress at the time was encouraging and that nearly all output level indicators were reaching 100% achievement, with a year left on the grant. Some findings from the midterm review that informed implementation of the project include:

- A total of 3,000 USD was allocated for minor renovations for the 154 dispensaries across Mbeya and Songwe. It was established the funds per facility were insufficient to cover costs of minor renovations and supervisions. It was further identified that these facilities earmarked for minor renovations had critical equipment gaps. In light of this, the review recommended filling the equipment gaps key to improving the survival of mothers and children. The assessment advised procuring additional equipment, including delivery beds, midwifery kits, digital blood pressure machines, fetoscopes, newborn resuscitation equipment, low reading thermometers, and haemagve machines.

- The midterm assessment also guided UNICEF to address the low rates of feedback about the health services received from lactating and pregnant women. To increase feedback, UNICEF was advised to reduce the number of questions asked as part of the feedback survey, to make it easier for the women to respond. UNICEF also reported that, after they integrated the feedback services with the community dialogues, they received enough feedback to develop scorecards that were used to further improve services at the project facilities.

- Drawing on the midterm review findings, UNICEF proposed KOICA consider a no-cost extension of six months to be granted to support the final implementation of project activities and ensure the sustainability of the projects’ strategy in the future. This was important to compensate for the time lost at the beginning of the project. A six-month no-cost extension was granted to extend the project
to June 2019 to allow enough time to complete a few pending activities and conduct a thorough endline evaluation of the project.

Support supervision

UNICEF funded biannual support supervision and mentoring activities that were also a means of executing quality checks on the level of service provision with regards to the different types of training received by the HCWs. Staff from UNICEF and the MNCH partners accompanied respective RHMT or CHMT members for this exercise in the project facilities. This team observed the HCWs as they provided services and reviewed different records to identify any gaps that needed to be addressed. Refresher training was offered to further build the HCWs’ capacity and improve the quality of service. Service providers who had not received prior project training also benefitted from the activity by receiving on-the-job training. The team also used this opportunity to check on equipment maintenance and general project progress.

Regular project monitoring

The project undertook regular monitoring, which was spearheaded by the UNICEF Mbeya Field Office with support from an independent consultant offering engineering expertise. The UNICEF Health and Nutrition Project Officers were also involved with the project’s monitoring activities. Quarterly monitoring visits with the engineer to monitor the quality of the construction resulted in the construction of relatively standard buildings across targeted facilities. The visits also were used to make progress checks and certify the disbursement of funds for the next quarter, address any challenges raised in project reports, and monitor supplies, verify reports, and document key findings. The regular monitoring activities also contributed to robust monitoring reports highlighting key achievements of the project progress and challenges, which informed mitigation approaches and revisions to project designs where relevant.

3.2.5 How effective were key partnerships and coordination mechanisms to realize the project objectives?

To what extent did the coordination between the national and sub-national government and working through government systems and processes enable or inhibit the achievement of the project objectives?

UNICEF partnered with the GoT at the national and sub-national levels. Partnership with the government at both levels facilitated a cordial working relationship, which resulted in a project that aligned with the government policies and priorities for MNCH programs in the region and, by extension, the nation. To achieve availability and readiness of RMNCAH services in the project facilities, UNICEF refurbished/renovated facilities, procured equipment, and built the capacity of R/CHMTs and the HCWs. The project trained the regional health managers as TOTs and enabled them to facilitate the training of the HCWs. This not only resulted in project ownership but left the region with a management team that has the capacity to sustain the training component of the project.

To ease the strain on service providers, the project relied on government partnerships to employ additional HCWs in facilities experiencing staff shortages that affected the quality of care. Some of the facilities still face staff shortages, which affects their overall availability and readiness to provide RMNCAH services.

UNICEF also partnered with the district council governments and district engineers to implement facility refurbishments and renovations. The government procurement systems were employed for the sake of future sustainability of the project activities. However, this resulted in some bottlenecks caused by the government bureaucracy that eventually not only raised the cost of the refurbishments but also delayed implementation, which affected the project timelines. Additionally, the government was also expected to supply water and electricity, which are essential in the provision of quality hygienic services. However, there were considerable delays that have affected the functionality of some of the refurbished facilities to date.
As one HCW in the IDIs from Songwe noted: “No, they [government] have not done any maintenance for the purposes of water systems. The water system has not been connected yet due to a shortage of water in our village.”

To achieve the objective of increased utilization of RMNCAH services, UNICEF partnered with the council governments who were expected to manage the ambulances by buying comprehensive insurance policies that would cushion against any damage via accidents. Unfortunately, one of the ambulances was involved in an accident and was written-off before it was reinsured.

A key informant from Mbeya RHMT stated: “The ambulance, which had an accident in Kyela, we had been asked to contribute towards its insurance, but people were reluctant. If we had insured it, maybe we would be given a replacement. We cannot blame the sponsor, but we also have to play our part. We also need to play our role in maintenance.”

To what extent did the partnerships and coordination with MNCH organizations enable or inhibit the achievement of the project objectives?

The MNCH partners were contracted to provide their training expertise to health management teams and HCWs. TTCIH-Ifakara provided task-shifting training for obstetric surgery and anesthesia, while LSTM worked closely with the government officials at both national and sub-national levels to develop training manuals that were harmonized with the national health guidelines and approved to be used in training. They were also tasked with building the capacity of the R/CHMTs to TOT level who work closely with LSTM in training the HCWs in MNH and quality improvement. By building the capacity of the R/CHMTs, UNICEF developed a pool of TOTs who will be key in sustaining the training component of the project through support supervision and mentoring. Involving the MNCH partners with the technical capacity and experience ensured a quality training managed by experts in that field.

A key informant from LSTM stated: “They were the target [R/CHMTs] so that they can perform monthly supportive supervision of the facilities...so the aim was to equip them with the knowledge and skills.... because every month we had the medical team with the doctors from Mbeya and Songwe, alongside the facility teams they would go visit the facilities for supportive supervision.”

### 3.3 Efficiency

#### 3.3.1 How adequate was UNICEF’s support of the project, including from the perspectives of different partners at the national and sub-national levels?

**Technical:** Was the technical support (i.e., building the technical capacity of health service providers) on essential maternal, newborn, and AFRH services adequate to achieve the outcomes of the project?

Capacity building was done at two levels, first with the health management teams (HMTs) and then the HCWs. The HMTs were trained on the development of MPDSR guidelines, which they indicated had helped in revamping the MPDSR meetings. The HMTs felt the guidelines were key in the identification of existing gaps in service provision that caused maternal and perinatal deaths. At output level, the project was able to put a significant number of providers through various training sessions covering topics of RMNCAH services, as shown below.

Numbers of HCWs in beneficiary regions/districts and facilities trained by component of RMNCAH

- FANC plus BPP training: 254 HCWs
- BEmONC including Active Management of the Third Stage of Labor: 217 HCWs
- Short skills EmONC training: 140 HCWs
- EmONC mentorship: 16 R/CHMT members
- Longer EmONC training: 60 HCWs
- Task shifting training for CEmONC: 21 HCWs
- KMC: 183 HCWs
- AFRH services: 184 HCWs
- Conduct of national integrated RMNCAH supportive guidelines: 17 supervisors at regional and district level and 125 health facility supervisors
- Quality improvement mentoring and coaching: 14 members of RHMTs.
- Quality improvement for maternal and newborn care and conduct of MPDSR: 91 HCWs

Note: Some HCWs benefitted from more than one training.

Consequently, this has led to a reduction in maternal and perinatal deaths in the two regions.

**An RHMT member in Mbeya stated:** “They [UNICEF] offered training on the development of death review guidelines and funded for meetings. If meetings are well designed, and there is a good strategy to be able to see the unseen through your strategy and is able to be functional, it is all thanks to the well-structured meetings. So, people come, you give reports of the previous meetings but always should have things to do with what you agreed upon with regards to certain conditions. This really helped reduce deaths of mothers and newborns.”

The technical capacity of the HMT members was also enhanced to enable them to carry out quality support supervision and to mentor on MNCH and AFRH services, in addition to being given the technical capacity to be TOTs of the HCWs in MNCH and AFRH services. Most of the HMT members at the regional and district levels indicated that the training was adequate to enable them to mentor and check the quality of services at facilities and sufficiently address any gaps realized.

**A CHMT member in Mbarali stated:** “Yes... As they received training... us too received....so that by the time we go for supportive supervision, we are aware of what is to be done and how to support them.”

However, a member of the HMT in Songwe region indicated that due to the formation of the new region, it also resulted in the formation of an additional RHMT and CHMTs that UNICEF had not factored into their initial budget. As a result, capacity building in Songwe was delayed, and the HMT member felt that the support provided by the project was not adequate. The reason for this was the appointment of new coordinators who were transferred into the region, some of whom did not get any training. The HMT in Songwe advised that there was a need for additional capacity building of the HMT members in the region for the sustainability of the project.

HCWs reported the different types of training they received at the facility level were adequate as they now were more skilled and competent while providing RMNCAH services compared to before they received the training. They also reported that, as a consequence, the women and adolescent girls and boys appreciated the improved quality of services provided at the facilities resulting in improved utilization of RMNCAH services. The HCWs highly appreciated training on EmONC services, which complemented their basic pre-service training and contributed to saving maternal and neonatal lives. The HCWs also indicated they had acquired new skills in providing efficient services to adolescents, courtesy of AFRH training. In their opinion, their technical capacity had been built to a level that they felt confident to offer on-the-job training to fellow providers.

**One HCW from Songwe stated:** “Starting with the youths, we thank KOICA, because there are some of the employees here who have been given training, I included, regarding services for the youths which at first, before the training, this service wasn’t there. We used to lose a lot of youths due to lack of knowledge about issues of the youths, but after getting the training, we have helped save a lot of youths.”
Capital investment: Was the capital investment in refurbishing or renovating strategic health facilities/dispensaries and procuring essential equipment adequate to achieve the outcomes of the project?

The main objective of the project was to reduce the number of neonatal and maternal deaths in the Songwe and Mbeya region by addressing the causes contributing to these deaths. The expected results included improved availability and readiness of quality RMNCAH services and increased utilization of these services. To achieve this, the project upgraded seven strategically located high-volume health facilities to be able to provide comprehensive emergency obstetric care so that women do not have to travel too far for life-saving interventions such as C-sections or blood transfusions, in accordance with the UN process standard. Eleven of these strategic facilities were provided with ambulances to enable women in obstetric emergencies to reach these facilities. Some of the 154 dispensaries received minor refurbishments, and all received basic equipment.

Subsequently, by the end of the project, 45 health facilities were renovated or refurbished and provided with better quality maternal, newborn and child health services; 18 of the 30 strategic health facilities provide all seven BEmONC signal functions, while three out of the seven selected CEmONC facilities provide all nine signal functions; over 640 health service providers have been trained and have knowledge and skills to provide quality reproductive maternal and newborn care services relevant to each level of the facility, and all strategic health facilities now provide AFRH services.

The amount allocated for the refurbishment of the 154 dispensaries was USD 3000 per facility. The 154 dispensaries were geographically scattered and remote, and UNICEF/distincts jointly realized meaningful (cost-effective) refurbishment would not be possible through engaging contractors. Further, a rapid facility assessment done as part of the midterm review identified critical gaps in essential equipment needed for quality MNCH services provision, and this was communicated to KOICA. Hence, the decision was made to focus on equipment gaps only in these 154 dispensaries. Four batches of equipment were procured and distributed during the entire project implementation duration.

The views from the sub-national key respondent and the HCWs are that the equipment and supplies procured enabled the provision of quality RMNCAH services for antenatal care. They facilitate the proper and thorough examination of pregnant women to identify risk pregnancies and plan early for referral, including regular blood pressure monitoring and checking for anemia; facilitation of clean and safe deliveries including by C-section; and enabling successful newborn resuscitation for babies born with difficulty breathing, particularly in cases of birth asphyxia, a leading cause of death in newborns.

The refurbished and renovated buildings, which led to the establishment of surgical theatres, maternity wards and AFRH, ANC and PNC service areas, provided the much-needed space to provide quality RMNCAH services. The availability of refurbished buildings, necessary equipment, and electrical and water services in some of the facilities resulted in the introduction of the inpatient EmONC services, and consequently, the increase in the utilization of these services through which maternal and neonatal lives were saved. The ambulances have also played a key role in emergency obstetric referrals.

One HCW from Kyela stated: “There’s been an increase in the number of clients. In the past, patients would look at the congested conditions and opt to go to private hospitals. But now there is enough space for privacy, enough beds, new mattresses, mosquito nets. Patients are comfortable and happy. Earlier on, there was too much congestion you know when you are sick you might feel like undressing when it gets too hot, but you couldn’t do that since next to you there was a stranger, but now there is enough privacy. Now patients have increased. They come from as far as Mbeya. We ask them why to have you come this far to seek treatment; they say that they are after the good service being offered there.”
that also contributed to saving the lives of mothers and their newborn babies.

**3.3.2 To what extent was the project management and coordination efficient?**

**To what extent was UNICEF’s coordination at the national and sub-national levels efficient?**

At the national level, UNICEF engaged with MOHCDGEC and PORALG from the onset of the project; this included involvement from the project design and planning stages to training (i.e., being part of the facilitators) and conducting quality checks of training materials and trainings. Representatives from the MOHCDGEC were involved in the supportive supervision activities and in the regional MPDSRs and felt the engagement with the project was satisfactory.

Due to staff changes at the national level, institutional knowledge about the project was limited, and since most of the project funds were channeled directly through the regional government, there was a lack of proper understanding around the background or history of the project. As such, a key respondent at the national level recommended that UNICEF could have included an “Advisory Committee” in the project organization and management structure. The respondent suggested the Advisory Committee members could have been drawn mainly from the various units of MOHCDGEC and PORALG, as well as from other development and implementation partners, to increase collective ownership of the project and its visibility at the national level.

At the sub-national level, the working relations were strong and more sustainable at the regional and district council levels. The working relationships at regional and council levels were clear, reliable with an explicit description of roles and responsibilities. The partnership started off at the project planning stage, where the sub-national level of government was involved in the preparation of the project proposal. They were also invited to sign the project MOU where the Regional Administrative Secretary (RAS) signed on behalf of the region, and the District Executive Officers signed on behalf of their districts. According to the KII with the Regional Medical Officers (RMOs) and select District Medical Officers (DMOs) of Mbeya and Songwe regions, the project design was well-received by the local government. The management structure employed by the project was felt to have ensured efficient execution of project activities by facilitating the timely disbursement of funds to implementation areas and open and prompt communication and coordination between UNICEF and regional and district government. In addition, the project management structure facilitated both the quality and timely procurement of equipment and supplies for the project by leveraging UNICEF’s strategic positioning in global health systems. Regional and council level officials appreciated the partnership, management and coordination of the project and attributed it to the recorded successes of the project. One key respondent from Mbeya RHMT stated:

“One key informant from RHMT from Mbeya region stated: “There was a lot of efficiency in procurement of equipment and the ambulances, a lot of transparency in available budget and spending, and efficiency in funds disbursement when authorities from our side fulfilled their part of the responsibilities on time.”

There was a strong sense of ownership of the project at the sub-national level, given the level of involvement of the regional and district level stakeholders throughout the project design and implementation.

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48 Some of the project funds that were channeled through the national government includes funds for MOH-national guideline development and dissemination as well as for some of the training directly implemented by the MOH officers and national trainers.
According to a key informant from Mbeya RHMT: “This project was ours. We owned it. The design allowed us to propose, decide, refuse or accept based on the benefits and feasibility of the decisions to be passed. Although it was known as UNICEF/KOICA project, to a large extent that was just a name.”

Through the district council meetings, UNICEF also made the budgeting process transparent by announcing budget allocations for each district council and the specific project facilities. District Engineers and UNICEF were involved in the process of preparation for the facility refurbishment/renovation by quality checking all the bill of quantities and plans that were presented by the contractors. This was facilitated by the Head of Supply Unit. This collaboration was extended during the construction period,. UNICEF hired a consultant engineer to visit the facilities undergoing renovation accompanied by UNICEF Program Officers, R/CHMT members and district engineers to check on progress and quality of work. All these initiatives improved the project efficiency to a recommendable extent.

Although the budgeting process was transparent, some officials at regional and district authorities stated the channels through which funds were disbursed for this project resulted in delays in the implementation of some activities. At the beginning of the project UNICEF sent out letters to each district to select their preference of how funds for renovations should be disbursed for their respective districts. Based on the choices selected by districts, in some districts the funds were released from UNICEF via the district councils, which later were paid out to contractors, whereas in other districts direct disbursements were made from UNICEF to the contractors. Further to this, districts had to also select whether funds were to be disbursed in advance of the works or on a reimbursement basis. At the time of liquidation or reimbursements, signed certificates of completion of work needed to be submitted to UNICEF prior to payments being issued. As a result of the disbursement process and reporting requirements, delays in some districts or units submitting reports held up funds and delayed implementation of some activities.

Note: UNICEF uses a harmonized approach to cash transfer to its implementing partners. This means as much as possible, funds for all activities supported by UNICEF to a partner are consolidated and sent in one installment to support activities that would be implemented and completed during a period of three months. Activity reports and a form called “FACE form” must be filled out to report on the fund transfer made. During UNICEF/KOICA construction works, the agreement with councils was to also include certificates of completion of works signed by the district engineer as part of liquidation documents to confirm the payment to the contractor was made following completion of a certain percentage of agreed works.

If funds stay with a partner for more than six months unreported, UNICEF’s financial system blocks the partner from receiving any additional funds from UNICEF. This system was made well known to partners when they were trained on UNICEF’s financial and administrative policies and procedures (HACT training sessions) at project launch, project monitoring visits, and joint annual planning sessions.

The decision to have UNICEF procure ambulances, equipment, and other supplies on behalf of the regions and councils was the most beneficial one regarding in terms of improving efficiency. The approach shortened the duration of the procurement process and saved costs, taking advantage of UNICEF’s ability to get lower prices on bulk purchases through its long-term agreements with manufacturers and suppliers globally.

To what extent was UNICEF’s coordination with MNCH partners efficient?

UNICEF’s coordination with MNCH partners was assessed at three different levels, namely the national, regional, and council levels.

At the national level, apart from the efforts demonstrated by UNICEF to engage the MOHCDGEC in its project design, implementation, and feedback, the project utilized national platforms where MNCH implementing partners (IP) met and worked together. Interviews with the project staff revealed that UNICEF had been attending and participating in several Reproductive and Child Health (RCH) and Community Based
Health Program (CBHP) - Technical Working Groups (TWGs), as well as other scientific platforms related to RMNCH. Through these various platforms, the project was able to communicate and share its learning from implementing the project, contribute to national policy dialogues and learn from other implementing partners about what does and doesn’t work.

At the regional and district council levels, UNICEF also proved to be an important partner during the development of regional and council health plans. In these planning sessions, it is common for all partners to attend and provide their technical and financial support to the regions/councils. Interviews with RHMT and CHMT members in Mbeya and Songwe confirmed the extent to which UNICEF was active in engaging other IPs (e.g., GIZ and Walter Reed) in its work for the sake of complementing the project activities.

Another dimension of how UNICEF coordinated its partnership with other MNCH partners was through the “Training and Capacity Building” initiative. UNICEF worked with both local and international training institutions (TTCIH-Ifakara and LSTM, respectively) to deliver quality training on MNCH services.

3.3.3 Were there feasible options for cost reduction and cost-saving specifically in relation to the capital infrastructure while realizing the same level of quality and results?

We addressed this evaluation question purely from a perception perspective. The view from the subnational stakeholders interviewed was the project could have reduced costs in two areas:

- **Use of district tender board:** According to some of the regional and district level key informants, they felt the procedure used for renovation/refurbishment which involved the District Executive Director's office increased the cost of this intervention because they felt that district tender boards were bureaucratic and incurred unnecessary costs during the tendering period.

- **Directing funds through health facilities and hiring community-based contractors.** According to a key informant from Mbarali CHMT, they felt that if funds were directed through health facilities and community-based local contractors were contracted for the refurbishment/renovations, the costs of the intervention would have been cheaper. The key informant stated the following: “This is what PORALG uses. They do not hire expensive contractors with names but use local contractors available in our communities, who are cheaper ten times.” In addition, some regional and district authorities who were interviewed stated the use of district council engineers to implement the refurbishment and renovation of health facilities contributed to poor quality of some of the renovations. They said this was due to poor supervision of contractors and delayed completion of work as a result of bureaucracy and untimeliness of council engineers. A member of the CHMT from Mbeya stated, “Engineers resulted in a long bureaucratic process in the tendering process of contractors for renovations.”

Taking into consideration the government’s viewpoint, a key informant from UNICEF felt that, while the local contractors can be cheaper, the quality of work might not be satisfactory and hence missing the sense of value for money. "I know this procedure, but I have conducted an assessment myself, and the quality of their work is not really impressive. Sometimes cheap is expensive," said the key informant. The informant further informed the evaluators that: "This option came later when the Government started construction of 300+ CEmONC health centers nationwide. At the beginning of the project, the only available construction modalities were through government processes or directly through UNICEF. UNICEF's implementation was not preferred because funds available per facility were small [renovation not new construction], and most of the funds would go to contractors as UNICEF bids would have attracted big contractors at the national level who charge highly for services and most of the funds would not have directly benefitted the facilities. The use of government processes was thus a decision made after several joint consultations between UNICEF, R/CHMTs, and Regional/Council Engineers."
Despite these concerns raised by subnational level key informants, UNICEF noted local authorities insisted on the use of local government procurement processes and implementation under district engineers during the planning stage of the project. It was surprising that this problem occurred because the same approach is used by PORALG to implement the construction and rehabilitation of public health facilities through the GoT’s special development plan for the health sector. We think the challenge was further compounded by lack of accountability in the District Executive Director’s office, which some of the UNICEF Tanzania’s Health Programme staff believed was contributed by to the lack of a formal Memorandum of Understanding (MOU) between the project and the office of District Executive Director. A key informant from the UNICEF Tanzania project team stated:

“We did not include any formal MOU with the district councils. We just had formal agreements, correspondences, and several management-level meetings, and we believed that that was enough. As a result, it was very difficult to hold accountable those who caused delays, bureaucracy and poor-quality deliverance.

3.4 Gender and equity

3.4.1 To what extent did the project design and interventions take into account the most vulnerable and hard-to-reach population?

The Tanzania Health Sector Strategic Plan IV identifies gender and equity as priority areas and defines vulnerable groups as those most affected by social and gender inequities. These include women, adolescents, children, people with disabilities, and the poor. The UNICEF/KOICA project design takes into account the unique challenges faced by women and adolescent girls in gaining access to quality RMNCAH services in Tanzania. By targeting vulnerable groups including poor, rural, women and adolescents, the project design has also factored in elements of UNICEF’s human-rights-based approach and aligns with Convention on the Elimination of all Forms of Discrimination Against Women and the WHO’s guidance on health equity.

The project utilized a multi-pronged approach to target and reach the hardest-to-reach and vulnerable populations. This included:

- The strategic selection and improvement of the quality and readiness of RMNCAH services of strategically located health facilities that provide access to health care to areas that are peripheral and remote was crucial to providing equitable access to RMNCH services across the two regions and 12 district councils.
- At the health facility level (i.e., the 30 strategic facilities and 154 dispensaries), the project design and interventions aimed to address equitable access and quality RMNCAH services through the training of HCWs, major and minor refurbishment/renovation of facilities, and procurement and distribution of essential EmONC equipment.
- At the community level, interventions such as the community facility dialogues alongside the MnM allowed the target audience to engage in discussions and provide feedback on the quality of the RMNCAH services offered at the facility level and thus contributing to increased access and utilization of the nearest health facilities. In addition, community shows and radio programs also aimed to target women who could not be reached at the facility level to increase education, awareness and demand for quality RMNCAH services.
- The ambulances provided by the project were key to addressing challenges related to transport for emergency referrals in the two regions. According to women in the qualitative interviews, the ambulances have contributed to increased access to higher level facilities in cases of emergency referrals. Some women also reported that access to the ambulances procured by the project has
helped reduce the financial burden of families who would not have been able to afford to pay for private transportation to a facility with a higher level of care.

**To what extent did UNICEF’s project design and interventions take into account the needs of pregnant teens?**

Tanzania is one of the African countries with a high number of adolescent pregnancies – more than one in four women aged 15-19 (27 percent) have at least one child or are pregnant with their first child. In the last ten years, pregnancies in this age group have declined by only 4% (TDHS, 2015/16). For adolescents, the quality of care within the maternal-child health continuum of care is critical to ensure a healthy and safe pregnancy. To reduce maternal mortality, an analysis of two decades of progress and gaps in reproductive, maternal, newborn, and child health to inform priorities for post-2015 recommends programs should take into account equity factors including socioeconomic access, geography specifically urban/rural zone, and maternal education. Furthermore, when access to health care is available, there are challenges with HCWs attitudes based on the social and cultural environment that prevent women, particularly adolescents, from seeking care at a facility.

Against this backdrop, the project included as part of its design HCW training on AFRH services and the introduction of AFRH services and practices across the 30 strategic health facilities. By the end of the project, HCWs across all 30 strategic health facilities received AFRH services training, which resulted in a 100% increase in the number of strategic health facilities providing AFRH from zero at baseline to 30 at endline. Now, these facilities provide a range of AFRH services to adolescents from counseling and testing for HIV to reproductive health including contraceptives, STI treatment, pregnancy care and post-abortion management. Other services offered include information and counseling on development during adolescence, including reproductive health, nutrition, hygiene, sexuality and substance use, management of sexual violence, and general health services for tuberculosis, malaria, endemic diseases, injuries, accidents, and dental care.

**To what extent were HIV prevention and quality of care to HIV-positive pregnant adolescent girls and women targeted?**

While the focus of the project was on maternal and child health survival, and not specifically HIV prevention or addressing the quality of care for HIV-positive pregnant adolescent girls and women, the project team engaged with UNICEF’s HIV section to include some aspects of HIV prevention as part of the AFRH services. Through the FANC and AFRH training provided to HCWs and the IEC materials distributed, the project did address services related to the Prevention of Mother-to-Child Transmission (PMTCT) and counseling and testing for HIV.

Even though the project has made significant improvements in setting up AFRH services across all 30 strategic health facilities, most of the facilities do not have enough space or staff to provide separate clinics for AFRH services, particularly for voluntary counseling and testing services. Therefore, some health facilities set up separate times for AFRH services to allow for more privacy and confidentiality when dealing with adolescents. However, adolescents are not always seen separately from other patients, as noted by some adolescents in the IDIs.

**To what extent were women and girls affected by disabilities reached?**

Qualitative findings revealed that there was limited exposure to those affected by disabilities at the health facilities. The design and targeting of the project did not incorporate a lens specific to the unique challenges faced by pregnant women and girls experiencing disabilities at the mental, emotional, nor physical levels. The project would have benefited from incorporating HCW training and community outreach to seek and

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provide services to pregnant women and adolescents facing disabilities to strengthen the equity and gender approach to reach the most vulnerable populations.

**To what extent were males involved in the intervention to encourage access and utilization of quality RMNCAH services?**

As part of the project interventions, HCWs were encouraged to invite and involve men in the reproductive and child health services including for BPP, PMTCT, ANC, etc. Qualitative findings revealed that health talks held at the facility level included male partners to increase their awareness of the importance of adequate nutrition for their pregnant partners. In addition, men were also targeted through community activities to increase awareness, demand and access to various health services. The community activities that targeted men included the community shows and community facility dialogues. Although men were not the primary target audience for the MnM service, some men in the FGDs reported that, since their wives used their mobile phone numbers to register for the MnM service, they also are educated as a result of receiving these messages.

**3.4.2 To what extent were sex and age-disaggregated data collected, monitored, and analyzed to inform the project?**

The project collected output level data against results specific to ensure the outcomes were achieved. Program level results focused on the achievement of outputs with indicators that targeted all women. However, as the project was implemented in partnership with the MOHCDGEC and District Health Information System (DHIS), at the health facility level, age and gender-disaggregated data were collected and monitored through quality improvement interventions to ensure an improved quality of RMNACH care for all women and girls served at the facility levels. Through reviewing DHIS data and collaborating with the MOHCDGEC, district health officers, and other key actors, UNICEF relied upon this data to inform the project design. However, the project documents, i.e., annual reports and results framework do not present age and gender-disaggregated data and therefore, it is not possible to measure the extent to which this data informed the project, as most of the data presented in the annual reports and results framework were not disaggregated by sex and age.

**3.5 Sustainability**

Factoring in sustainability strategies is usually part and parcel of any important and substantial investment, such as the UNICEF/KOICA project. We identified two types of sustainability strategies related to this project – the intended (planned) and unintended.

**Intended sustainability strategies**

At the onset of the project, measures were identified and strategized to ensure the sustainability of the project. These included:

- **Technical sustainability**

  Technical sustainability was expected to result from the capacity building intervention through training of service providers on essential MNCH and AFRH services. It was expected that a pool of mentors would be developed at regional and district levels to render hands-on competency, supervision and mentoring, and provision of MNCH and AFRH services. The increased capacity would then result in better quality services, which, in turn, would lead to better long-term health outcomes for children, women, and adolescents.

  The evaluation team was able to elicit information from various reports and through interviews with RHMT and CHMT members in regions and districts of Mbeya and Songwe, that confirmed this sustainability strategy. The same was said by various key informants who were interviewed and who identified themselves as mentors and trainers who benefited from this project and have become a resource not only for Mbeya and Songwe, but also occasionally are used by the MOHCDGEC to conduct training in other regions.
However, this sustainability strategy was challenged by service provider turnover especially as a result of the "national form four certificate authentication,"\(^5\) which affected a significant number of health sector government employees, some of whom had received the capacity-building investments. In between, few new service providers were either recruited or transferred from elsewhere and needed similar training. Despite having mentors and trainers in regions and districts, funding has also been an obstacle to fulfilling the sustainability goal.

**Sustainability through innovation**

The project aimed to work closely with the MOHCDGEC mHealth focal point through regular consultations on the MnM service. The mHealth team was expected to be involved in all stages of the development and piloting of the MnM innovation, which would have been based on national guidelines, thus ensuring the transfer of technical expertise and sustainability. The evaluation was not able to confirm the integration of MnM in the current government platform "Wazazi Nipendeni" however, the UNICEF innovation team has indicated this is the intention of the project. Other domestic partners (UMATI, in particular) have adapted the MnM and community-based innovations in general in their own activities in the Mbeya region, building on what UNICEF initiated.

Other community level activities lead by BCC Media Action has provided capacity-building training to five local radio stations on how to produce programs that engage the community and cover RMNCAH topics so that these radio stations could continue to produce such programs in the absence of the project. Some of the content and messages developed by the project has been integrated into the national MOHCDGEC drama popularly known as “Zinduka.” The radio soap opera has been airing for many years and is a vehicle for educating mass audiences across the country about health issues. Lastly, CHWs engaged in the community level interventions have acquired knowledge and awareness on RMNCAH topics that they are likely to use in future engagement with community members.

**Ensuring sustainability through strategic selection of health facilities to promote quality**

The project tested and demonstrated the impact of a strategy that strengthened selected facilities with high-quality delivery services. The successful impact was expected to guide policy to effectively reduce maternal and newborn mortalities.

The evaluation found, while this approach worked and improved the quality of services, it is yet to be adopted anywhere else across the country for replication. While it might be too early to see if the learnings might be applicable elsewhere, adapting the strategy to other areas requires proper and systematic documentation to sufficiently explain how it works, and its impact on improved quality of care and improved accessibility of RMNCAH services needs to be scientifically documented.

**Sustainability through elevated community knowledge on RMNCAH issues**

The community-based interventions intended to increase the knowledge of its members, especially pregnant women and caregivers of children less than five years old, on the availability and importance of uptake of RMNCAH services. It was expected that, over time, shifting social attitudes, structures, and norms regarding maternal and child health behaviors would result in reduced maternal and infant mortality and reduced adolescent pregnancy and new HIV infections among adolescents. Unfortunately, these are long-term outcomes and impact parameters that were not covered by this evaluation.

However, both qualitative and quantitative data showed an increase in awareness and knowledge among community members on RMNCAH issues that were targeted by the project. In addition, the CHWs involved in this project will remain a good resource for creating awareness on RMNCAH at the community level,

\(^5\) About 10,000 civil servants nationwide were fired after an investigation which found that some government workers had been occupying their positions with forged secondary education certificates.
notwithstanding that CHWs are volunteers, thus there is no guarantee how long they will continue to raise awareness.

**Unintended sustainability strategies**

One of the unintended sustainability strategies was the extent to which the project activities coincided with emerging policy decisions in the country. At the time the project was being implemented, the GoT changed the Basket Fund disbursement procedures from centralized (through the District Executive Director accounts) to a decentralized approach (through Direct Facility Account). This approach gave facilities the mandate to plan, budget, and spend resources based on their facilities’ specific priorities and in a timely manner with less bureaucracy in accessing the funds when needed. Interviews with several key informants revealed that health managers and service providers were happy with this approach and believed that Direct Facility Account would facilitate sustaining the project’s impact, especially when they need to procure and replace equipment and supplies.

The second unplanned sustainability strategy is related to the project intervention on refurbishment, renovation, and upgrading of some of the selected health centers from BEmONC to CEmONC facilities. While implementing the project, the GoT passed a new directive to identify and select some strategic health centers to upgrade or, in some instances, build new facilities but at the CEmONC level. The GoT is doing this across the whole country including Mbeya and Songwe regions, hence increasing coverage of health centers with the ability to provide CEmONC services in the two regions (beyond the seven strategically selected health centers supported by UNICEF).

Finally, at the end of the project, the MOHCDGEC received recommendations from the WHO through the MNCH Quality of Care Network of which Tanzania is a member to improve the quality of RMNCAH services. Among the recommendations was “identifying and selecting learning hubs” where resources would be concentrated in a small area and track what works and what doesn’t work with regards to context-specific factors. This is similar to UNICEF’s approach to the strategic selection of the 30 health facilities. UNICEF coordinated the meeting between WHO and MOHCDGEC from which these recommendations and guidance were provided. It is the intention of the MOHCDGEC to learn from Mbeya and Songwe as a starting point when implementing the WHO recommendations.

### 3.5.1 What were the enabling as well as constraining factors that influenced the sustainability of the project?

**Enabling factors**

- **The project design was participatory and involved the regional, council, facility, and community stakeholders hence creating a strong sense of ownership.** Although the project was termed as the “UNICEF/KOICA project,” health managers at the regional and council level highly appreciated the feeling of being central to the group running the project.

- **The alignment of the project interventions and activities with the local priorities.** The choice of interventions was also an enabling factor. According to the interviewed key informants, having the local and ground teams decide which interventions they thought were their priorities was very helpful to sustainability. Ambulances will be used for a long time, and when completely depreciated, the district councils are likely to plan for replacement after many years of seeing their value. Refurbishment/renovation of health facilities and equipment donated will last for a long time, and the CHMTs and health facility in-charges have indicated an intention to include in their district and facility plans, respectively, budgets for ensuring the upkeep of the refurbishment or replacing equipment as needed.

- **The alignment of the project focus and interventions with national priorities.** As described under the relevance section, this project focus was well aligned with the national priorities for
RMNCAH services. As a result, there was no need for advocacy on “what to do” but only the “how to do it,” which involved the innovation component.

- **Use of local and international partners.** This provided capacity strengthening based on the experience of local as well as international partners and hence the sustainability of knowledge and skills. During an interview with members of the LSTM, Tanzania based LSTM team members expressed that they felt capable and competent enough to continue supporting the two regions as they embark on sustaining the project activities. They also felt they were able to support other regions across the country using the knowledge and skills acquired through the project.

- **The multi-sectoral approach,** especially with respect to the refurbishment and renovation activities. This intervention involved several sectors at the district council level (health, water, electricity, education, and construction and engineering), which were all necessary based on the nature of the activities. This approach enhanced timely and appropriate delivery of the required services to accomplish facility refurbishment and renovation.

- **Inclusion of tangible interventions such as ambulance vehicles, renovation of health facilities, and procurement of equipment.** These interventions won the hearts of many community members and built trust in the project and increased their participation in project activities. In many of the FGDs and KII s, community members and other stakeholders referred to these concrete resources as among the most valuable and appreciated components of the project.

**Constraining factors**

- **Availability of funds to sustain regularly supportive supervision and mentorship activities.** The R/CHMTs lamented that due to a small health budget, they are not able to conduct regular supportive supervision and mentorship activities. According to one of the RHMT key informants from Songwe, “For example, we have not been able to conduct supportive supervision this quarter because we do not have resources for that.”

- **UNICEF’s centralized and sector – collective system for fund disbursement.** UNICEF uses a harmonized approach to cash transfer to its implementing partners. This means as much as possible, funds for all activities supported by UNICEF to a partner are consolidated and sent in one installment to support activities that would be implemented and completed during a period of three months. As such when UNICEF supports a region or council and if there are multiple activities in the same region or council involving several sectors (e.g., education-related project, health-related project, and water-related project), fund disbursement will depend on the council’s ability to supervise, implement and provide a timely report that includes all sectors together. Any delay in one of the sectors will lead to other sectors facing a delay in receiving their funds. During the evaluation, key informants from the health sector expressed their concern on this approach and associated it with delays of some of their activities.

- **The voluntary nature of the working of CHWs.** During the project implementation, the GoT planned to change the modality of working with CHWs from the volunteerism approach to a paid cadre. Unfortunately, this intention was not implemented, and the government is back to sustaining the volunteer way of working for CHWs. While during the project implementation, UNICEF was able to provide stipends for CHWs engaged in the project, the lack of stipends might affect the sustainability of some of the community level interventions now that the project has ended.

**To what extent did the project establish processes and systems that are likely to support the continued implementation of the project?**

There are four ways in which the project can ensure the processes, methods, tools, and systems developed in the course of the project implementation are sustained and possibly scaled up. These include:
(ii) **Policy influence through national MNCH guidelines:** According to national level key informants, the three national guidelines, “National Guidelines for Neonatal Care and Establishment of Neonatal Care Unit,” Integrated RMNCAH Supportive Supervision,” and the “Maternal and Perinatal Death Surveillance and Response Guidelines,” are by-products of the project, that will be sustained in the long term.

“These were developed mainly with technical and financial support from UNICEF together with other RMNCH stakeholders. It will remain to be their living legacy”, according to a key informant.

(iii) **Capacity building of health managers, mentors and service providers:** The initiative to build the capacity of health managers at the regional and council levels have left behind permanent resources for R/CHMT members to allow them to continue providing leadership through supportive supervision and mentorship and also to play the role of Trainer of Trainees (TOT). The TOTs can be used to train on quality supportive supervision, mentorship, KMC, quality improvement and MPDSR anywhere in the country. Under the training initiative, there are also service providers who received both basic on-the-job training as well as training on continuous supportive supervision and mentorship hence making them competent even beyond the project.

(iv) **Development of reference materials such as job aids:** In the course of implementing the project and in conjunction with the training initiative, the project has left behind a number of handy tools that are applicable at service delivery levels such as job aids and SOPs. These are living resources, and some CHMT members acknowledge the ease of reproducing these materials for future use.

(v) **Changes in attitudes and perceptions among communities of improved utilization of RMNCAH services:** Finally, the community awareness and demand creation initiatives have also left behind both systems, community knowledge, and a change of attitudes and practices that will remain. The MnM platform is under discussion to be integrated into similar national level platforms and is likely to be managed by the MOHCDGEC and hence be scaled up countrywide. UMATI is using the MnM platform beyond the project period to implement community-based initiatives with additional innovations under the community dialogue initiative.

### 3.5.2 What could or should be done differently in future replication and scale-up of the project?

To ensure the take up of the project activities that yielded the most impact for replication and scale-up, it is important that learnings from the project are maintained at the national level. The evaluation found that due to staff changes over the course of the project implementation at the national level, institutional knowledge about the project was limited, and since funds were also channeled directly through the regional government, there was a lack of proper understanding around the background or history of the project among key informants that were interviewed. As such, a key recommendation from the national level was for UNICEF to establish an “Advisory Committee” in the project organization and management structure from the onset, comprised of members from the various units of MOHCDGEC and PORALG, as well as from other development and implementation partners, to increase collective ownership of the project, visibility at the national level and retention of learnings for replication and scale-up opportunities.

The evaluators did not have enough information on the past experience on accounting and funds disbursement procedures used by UNICEF when working with district councils. The system of having district councils provide financial reports that incorporate funding received from UNICEF all sectors/sub-sectors in one joint report prior to disbursing funds for the next phase has been a subject of some criticism. The health sector’s perspective is that even when they deliver their reports early enough, they still experience delays in receiving disbursements. This is one area that UNICEF may want to review as it looks to future initiatives.
Supply-side: What aspects of the project design and implementation approach could or should be adapted for future replication and scale-up of the project?

During the interview with MOHCDGEC representatives, it was indicated that the decision to have UNICEF conduct massive procurement on behalf of its partners is not new and was in place even before this project. It was also made clear that when it comes to quality, the option to work with UNICEF is the preferred one whenever the GoT can justify procurement through UNICEF. There is an overall agreement among respondents interviewed at the national and district level that, with UNICEF, there is value for the money for procured equipment and supplies.

A few key informants proposed to continue using local organizations such as TTCIH-Ifakara to deliver capacity building courses. They justified this for two reasons: they perceive it to be less costly, and they help to strengthen local institutional capacities.

From the quantitative results, it was apparent that both readiness and coverage of most of the health facilities to provide EmONC services have improved within the project period compared with baseline. This suggests that the multi-intervention approach that UNICEF employed might be feasible and the right approach to take in the future for many programs compared with single intervention projects.

Demand-side: What aspects of the project design and implementation approach could or should be adapted for future replication and scale-up of the project?

Although the community awareness and demand creation component had several interventions (including use of posters, radio campaigns, and others), the majority of the evaluation participants showed more interest in MnM than in the rest of the interventions. Despite the fact that in rural settings, not everyone has a phone, this intervention was still the favorite for many people. It was even more meaningful when the innovation was tied to the development of an inventory of issues for community dialogues.

In addition, the use of existing community structures such as the use of Health Facility Governing Committees and other community-based committees proved to be effective in holding the health system accountable, ensuring outreach to the majority of the community members while improving community participation. Whenever possible, such structures should be considered in the project design.

3.5.3 How will good practices generated from the project be brought into and sustained at both national and sub-national levels?

Listening to the tone of various interviewees that were involved in the evaluation, there are several ways through which learning can be used to make the implementation approach and design that UNICEF used adaptable and replicable. These include:

- **Joint planning of a project with key stakeholders under the leadership of the government.** The participatory approach that UNICEF used helped secure buy-in of the project from onset to the end. Despite some dissatisfaction from a few of the key stakeholders with the extent of their involvement, overall, ensuring that “no one is left out” in all steps of implementing a project is a component that should be considered a best practice.

- **Choice of interventions that find a balance between supply and demand sides is also crucial.** UNICEF was able to align the selected set of interventions to the national priority framework but also able to merge it with local priorities.

- **Choice of feasible and context-specific interventions.** According to one of the RHMT members from Mbeya region, most of what was implemented was actually feasible in the sense that they were doable and could be replicated in other places because they have considered the Tanzanian context. A key informant said, “The Tanzanian context is almost similar to our context in Mbeya.”
That's why the government bought the idea of the Uturo model, for example, and now it is scaled up across the whole country."

- **Interventions that offer value for money.** Most of the interviewees did not have a sense of actual spending on the project across all interventions. However, they perceived that whatever amount of money that was spent, there was value for the money. This, in particular, is an important factor when considering adaptability and replicability.

### 3.5.4 What are the good practices and key conditions for national scaling-up of the project?

Interviews with national and sub-national level informants provide an overview of officials' expectations of these types of projects if they expect the project to be scaled up. During an interview with a MOHCDGEC official, the official indicated that one of the reasons that many projects end up on shelves is the lack of **integration in the national health priorities and framework.** "Some projects are out of context and sometimes not our priorities. I would not even lend you my ear with such projects," he said.

Closely related to this, another interviewee at the national level said that the project should also bring in **interventions that have been proven to work.** "We don't want to have projects that are for the sake of piloting the interventions. Piloting should only be in testing the operationalization but not testing whether the intervention works or not," she said.

Other good practices for scalability that various interviewees suggested including having a **shared vision of the project across a wide spectrum of key stakeholders,** and **frequent updates of the project progress,** especially if the project is implemented for a long period of time and demonstrating contextual and cost feasibility.
4. Conclusions

1. Relevance

The evaluation found that the project design results and implementation strategies were relevant to the national and sub-national contexts, strategies, policies, and programs. From the perspective of the country context analysis, the project was established at the time when many RMNCAH indicators in Tanzania, in general, and in Mbeya and Songwe regions, in particular, were performing poorly. Maternal and neonatal mortality were high; quality of RMNCAH services was compromised with numerous health system issues, utilization of health services was comparatively low, and coverage and availability of AFRH services were low. Also, the project objectives, planned outputs and outcomes were all aligned within the policy framework and GoT’s commitments as described in Tanzania’s Vision 2025, the second Five Year Development Plan, the Tanzania Health Policy (2007), as well as the New Health Policy Draft (2020), Health Sector Strategic Plan IV, the RMNCAH Road Map (2016 - 2020) and the National eHealth Strategy (2013).

The relevance of the project was also seen from the design aspect. The design employed a set of strategic plans that the country, with its development and implementing partners, had decided to pursue. The decision to implement RMNCAH holistically was in alignment with both the GoT guidelines and WHO recommendations. The project design and implementation were widely accepted and praised by a wide range of stakeholders at the national and sub-national level, as well as by the targeted primary beneficiaries (i.e., pregnant women, newborn children, children under-five and adolescent girls and boys (10-19 years) in the 12 districts across Mbeya and Songwe region.

2. Effectiveness

The project has made significant strides in improving the availability and readiness of the target health facilities to provide RMNCAH services in both Mbeya and Songwe. This is demonstrated through the increased capability of the strategic health facilities to provide the seven BEmONC and nine CEmONC signal functions, proper use of partographs, and the availability of AFRH services. The improvements observed are a contribution of the refurbishment and renovation, procurement, and distribution of equipment, as well as training of health care workers. Over the course of the project lifetime, the number of strategic health facilities providing all seven BEmONC signal functions increased from zero at baseline to 18 health facilities at endline. Among the remaining 12 facilities that were not providing all seven BEmONC signals, the most common functions that were not being performed at endline include MVA (nine facilities were not performing this function), AVD (eight facilities were not performing this function) and MRP (four facilities were not performing this function). The main reasons cited by the facilities for not being able to perform these signal functions include the lack of trained personnel or functional equipment. While the project trained HCWs across all 30 health facilities on all BEmONC signal functions, staff transfer and turnovers are likely contributing factors to some facilities reporting the lack of trained staff to take on these functions.

The project targeted seven health facilities to be upgraded to CEmONC levels, which includes the capacity to undertake all nine CEmONC signal functions. By the end of the project, only three out of the seven targeted health facilities could provide all nine signal functions. Five out of the seven facilities were capable of providing C-sections relative to only one facility at baseline. Similarly, six out of the seven facilities could provide blood transfusions at endline, which is a major improvement from baseline, when only one facility had that capability. Across the nine CEmONC signal functions, two out of the seven facilities did not perform AVD and one facility could not perform MVA, thus resulting in only three out of the seven facilities having the capacity to perform all nine signal functions by endline.

Although the project was not able to meet its intended target for all 30 health facilities providing all seven BEmONC signal functions, and seven target health facilities providing all nine CEmONC signal functions as part of their routine functions, by the end of the project, it was successful in increasing the capacity of the targeted health facilities, overall.
In addition, the project contributed to improvement in the quality and readiness of RMNCAH services in a number of other areas. As part of the project, AFRH services were established and HCWs were trained on providing the services across the 30 strategic health facilities, services that did not exist at baseline. All health facilities continue to use partographs, filling them out properly (how the forms were being filled out showed marked improvement over the course of the project). Other areas include upskilling HCWs through training and providing essential equipment for improvements in ANC, delivery, and PNC services, and established KMC services through skill-based training of HCWs and supportive clinical mentorship across select district hospitals and health facilities.

The project also established Maternal and Newborn Workplace Improvement Teams across all 30 health facilities and strengthened supportive supervisions through technical support via training and accompanying supervisors to quarterly visits. The project also supported the finalization of Tanzania’s RMNCAH Integrated Supportive Supervision guidelines, which will contribute not only to the improvement in quality of care and RMNCAH service provider accountability in the target regions and districts, but in the country as a whole. Alongside the supportive supervision, the project supported all 30 strategic health facilities to conduct monthly MPDSR and provided technical and financial support in the development of MPDSR guidelines and tools, printing and dissemination. Lastly, the project contributed to strengthening the existing referral system in Mbeya and Songwe regions by procuring and strategically distributing 11 ambulances across the target districts.

**Achievement of increased utilization of RMNCAH services are positive with the project meeting the majority of its targets.** The improvements in the availability and readiness of RMNCAH services has contributed to changes in the perceptions and attitudes of women (15-49 years) seeking care within Mbeya and Songwe regions about the targeted health facilities. Women reported noticing improvements in services over the course of the project ranging from better equipment, less waiting times, and friendlier staff, among others.

The project has seen statistically significant improvements from baseline to endline in the number of pregnant women attending four or more ANC visits (68% to 86%, respectively), receiving IPT during their ANC visits (70% to 91%, respectively), and an increase in the number of live births attended by skilled personnel for the most recent birth (83% to 95%, respectively). Targets for pregnant women attending four or more ANC visits and receiving IPT have been met. Similarly, the project also contributed to the increase in the number of mothers initiating breastfeeding within an hour of birth (58% to 80%, respectively) and very small improvements in those women seeking PNC within 48 hours of giving birth (16% to 19%, respectively). These changes are not statistically significant. The number of mothers who attended their first ANC within 12 weeks of their pregnancy was at 56% at endline.

**Awareness levels among women, their husbands, and their fathers and mothers-in-law on the value and importance of women visiting health facilities for ANC, delivery, and PNC were over 90% at baseline and have only seen an upward trend over the course of the project (reaching 100%).** Some of the project’s contributions to raising awareness and demand for RMNCAH services include the community and facility dialogues which have helped to encourage husbands and women to seek ANC services as early as possible; prepare for transportation to the health facility for women in labor through BPPs; the counseling women received at the health facility during their ANC visits around the danger signs they should look for during their pregnancy, delivery, and post-delivery, as a result of the training that HCWs received; and the information shared via the MnM service and IEC materials around their pregnancy, but also the opportunity to provide feedback on the services received via the MnM service, and through the community scorecards as part of the community-facility dialogues. The improvements in the readiness and availability of RMNCAH services have also contributed to women more easily accessing the services they require closer to their homes, reducing the transport costs necessary to seek specific services far outside of their communities.
Some of the project activities were perceived to have a more significant contribution than others. These include:

- **Building the technical capacity of healthcare workers.** HCWs felt that with proper training received, the renovated/refurbished buildings and donated equipment are being put to proper use resulting in availability and readiness of quality RMNCAH services. Specifically, EmONC training on resuscitation of neonates, administration of anesthesia, conducting obstetric surgery (C-section), and KMC have been significant in saving the lives of mothers and their newborn children.

- **The procurement of 11 ambulances for emergency obstetric referrals.** At the community level, the feeling is that a gap still exists in emergency referral services as the ambulances are not adequate in relation to the population and geographical size of the regions. Despite this, the sub-national government felt that the ambulances made an impact on the reduction of maternal and neonatal deaths by ensuring that those in immediate need of critical EmONC services are referred in good time to a suitable referral facility.

- **Community and facility dialogues.** The majority of the project beneficiaries reiterated how the advice they received from an interpersonal communication session with HCWs either at the facility or in the community made them adopt the desired behavior of seeking RMNCAH services.

**3. Efficiency**

Managerial and coordination efficiency was highly observed at the national and sub-national government levels. The evaluation findings showed the project successfully integrated its activities with the sub-national and council level programs of work, drew joint plans, exercised transparency in budget allocations for various interventions, and jointly conducted supportive supervision and monitoring of the project activities. According to the project progress reports, compliance with the timeline was very high, and the project made significant progress to meet various set targets, with the exception of some delays at the onset of the project. Efficiency in managerial and coordination aspects of the project was also fairly found with other MNCH partners as well as at the project level.

**4. Gender and equity**

The project design and implementation contributed to reducing inequalities and gender disparities by targeting and reaching many of the most vulnerable women and adolescent girls in the Mbeya and Songwe regions through its multi-pronged implementation approach. To address inequitable access to RMNCAH services across the two regions the project improved the quality and readiness of RMNCAH services in 30 strategically located health facilities that provide access to health care to areas that are peripheral and remote across the 12 districts. The project established and supported AFRH services across all of the strategic health facilities, which has contributed to increased access and the overall experience for adolescent mothers by shortening their waiting times, customizing their ANC services, and increasing privacy.

The project also contributed to increased health awareness and practices at both the health facility and community level. At the health facility through trained HCWs the project ensured that women and adolescents received the appropriate counseling during the ANC visits, delivery and PNC. HCWs also encouraged the participation of male partners as this was key component of the trainings and community level awareness initiatives advocated by the project. At the community level the project raised awareness to increase demand and access to RMNCAH services, through community shows and community facility dialogues. The content of these community level interventions encouraged male participation to encourage access and utilization of quality RMNCAH services for their partners.

One key drawback in the project design was that it did not factor in interventions specific to women and adolescent girls that face disabilities. The project would have benefited from incorporating HCW training and
community outreach to seek and provide services to pregnant women and adolescents facing disabilities to strengthen the equity and gender approach to reach the most vulnerable populations.

5. Sustainability

The project has been successful in establishing processes and systems that are likely to support the continued implementation of the project. These include:

- Influencing policy through technically and financially supporting the development and rollout of MNCH guidelines, namely "National Guidelines for Neonatal Care and Establishment of Neonatal Care Unit," Integrated RMNCAH Supportive Supervision" and the "Maternal and Perinatal Death Surveillance and Response Guidelines."

- Capacity building of health managers, mentors and service providers to provide quality RMNCAH services and continued supportive supervision and mentorship in the target districts and wider country.

- Changing attitudes and perceptions among communities on improved utilization of RMNCAH services through the MnM service, which is under discussion to be integrated and adopted by the national government.

- Development of reference materials such as job aids that remain as living resources for both service providers and regional and district councils to reproduce and utilize for future use.

Some of the key enabling factors for sustainability include the highly integrative and participatory approach taken by the project. This has created a sense of ownership among stakeholders at the sub-national, council and community levels, project responsiveness to the real issues and priorities of the locals, as well as the availability of capable health managers and service providers with enabled competence to implement the same quality of service routinely. One key constraining factor for sustainability is the availability of government funds to continue the implementation of some key project activities such as routine supportive supervision and MPDSR meetings now that the project has ended.
5. Recommendations

1. UNICEF should, as soon as possible, share learnings and good practices emanating from the experience of 'strategic selection of health facilities for improving quality and readiness of RMNCAH services' to the MOHCDGEC and PORALG to inform national scale-up strategies and current government directives around upgrading of selected health centers to provide CEmONC services. This can be done by developing policy briefs or short reports that describe the strategy and processes involved as well as by conducting dissemination meetings with the two ministries.

2. The offices of RAS for Mbeya and Songwe, which are responsible for overseeing all sectors in the regional level, should, as soon as possible, bring together sectors responsible for energy (through TANESCO) and road construction (through TARURA) to address and prioritize issues of power availability and road improvements in catchment areas of the "strategically selected health facilities" in order to optimize and complementing the project outcomes as well as sustaining the project achievements. UNICEF can support this effort by sharing this learning with RAS office during dissemination sessions with sub-national levels and through a concise brief.

3. UNICEF should plan to disseminate the findings of the project outcomes to key stakeholders at the national and sub-national government and the wider MNCH stakeholders involved in the project. The dissemination content should be targeted at specific types and levels of stakeholders. This will be a motivation for the regions, councils, health facilities, and community to sustain the good outcomes from the project.

4. The mHealth section at MOHCDGEC should in the near future, build on the success of MnM and integrate it within the National "Wazazi Nipendeni" program. Specifically, the use of the MnM service in improving quality of care and accountability at the health facility through feedback on services received and reminders on PNC/ANC appointments. This can be achieved through a series of discussions engaging the innovation team from UNICEF on operability and synergy of the two systems.

5. The Regional Administrative and Local Government (RHMT and CHMT), needs to develop and implement human resource capacity development plan aimed at sustaining the trainings and skills developed by the UNICEF/KOICA project through the use of trainers and mentors at the national and sub-national level. This should be implemented as soon as preferably by integrating the plan within the next planning cycle. The plan should be practical and sustainable by allowing for skill transfer to new staff and also upskilling existing staff with refresher trainings based on needs identified through the supportive supervision visits and ensure they are tied to BEmONC and CEmONC signal functions.

6. PORALG should support the RHMT and CHMT by allowing regions and councils to allocate sufficient funding for the human resource capacity development plan and capacity building activities. This can be considered in the forthcoming planning cycle.

7. The Reproductive and Child Health Section at PORALG, needs to ensure sufficient budget are provided to regions to conduct regular supportive supervision of the strategic health facilities to (i) assess availability and functionality of equipment and buildings supplied by the UNICEF/KOICA project; (ii) identify any skill gaps and address through mentorships and trainings and (iii) ensure MPDR are being conducted regularly by health facilities in accordance to the government guidelines.
6. Lessons learned

Learning from project design

- The holistic approach that the project undertook (addressing the overall continuum of care of RMNCAH) is a good learning example for other projects. There is enough evidence that a singular approach in the health system might have the most significant effect only during a pilot project but less contribution to addressing health system challenges in a routine and real setting.

- The decision to directly concentrate resources and efforts on 30 strategically selected health facilities created a learning hub where the effects of these pooled efforts and resources could be systematically observed. This is in tandem with the WHO - Quality of Care Framework, where it is highly recommended to implement programs in strategically selected hubs, especially when resources are a constraint.

- Plans for the sustainability of project outcomes start at the planning phase of the project, not at later stages. The evaluated project was a good demonstration of this approach. The project conducted a useful review of implementation requirements and included sound sustainability strategies from the beginning that included:
  - a highly integrative and participatory approach that created ownership of the project among stakeholders at the sub-national, council and community levels;
  - project responsive to the real issues and priorities of the locals, as well as the availability of capable health managers and service providers with enabled competence to implement the same quality of service routinely.

These justifications led to the choice of the type of innovations and interventions to be implemented.

Learning from project implementation

- In future, projects lead by UNICEF which are multi-year and involve partnerships with multi-stakeholder involving national, sub-national and other partners would benefit from establishing an advisory at the onset of the project comprised of key representatives from MOHCDGEC, PORALG, regional authorities and other relevant stakeholders to maintain institutional knowledge and sustainability of project activities even if staff leave posts. The role of the advisory committee members can include guiding and informing the project on policy and strategic dynamics, but they also could communicate project progress reports to the wider MOHCDGEC and PORALG audiences. Reports that are usually shared with donors could also be shared with the advisory committee so that the national and sub-national level decision-makers are kept informed on the project’s progress on a regular basis.

- The participatory approach that the project adapted was key in creating ownership of the project at all stages of its implementation. However, a balance needs to be maintained between managing the project according to agreed protocols/SOPs and allowing for flexibility. It was because of the participatory nature of the project, with the intention of creating ownership of the project, that several cases of delays, as well as instances of compromising the quality of some of the project outputs, were noted. This is a tough situation, especially when working with the Government bureaucracy and where partner institutions like UNICEF are unable to hold the other partner accountable.

- In ensuring that project milestones are met, agreements, protocols, and SOPs alone are not enough. A strong embedded monitoring component by the project team must be part of the main project activities. UNICEF’s decision to have officers at the local authority level and the frequent
monitoring visits helped to ensure that timeliness and quality of outputs and outcomes from project activities were achieved.

- Conflicting partner organizational policies need to be considered in project planning. **It is essential for participating partners to understand other partners’ policies when working together.** UNICEF’s decision to orient its partners on its fund disbursement procedures helped to keep the challenges to a minimum. That would not have been the case without the orientation.

- While the diversity of interventions the project included in its plans was applauded for being holistic and comprehensive, such diversity calls for massive managerial efforts and resources as well as close supervision to ensure activities are properly conducted. It is, therefore, important for those who are going to use these findings and learning for other projects of this type to underscore the importance of ensuring that the project has sufficient workforce to handle the magnitude and volume of work required.

- **UNICEF project team needs to strengthen the M&E framework development and ongoing revisions.** Specifically, the indicator definitions used throughout the project results framework and subsequent monitoring reports and the baseline values and target need to be appropriately reviewed to ensure the consistency, the baseline values utilized need to be accurate, and the subsequent targets set need to align with the baseline values. All revisions and updates to indicators or baseline values during the project lifetime need to be adequately documented and reflected in the original PDM (results framework).

**Learning from project outcomes**

- The promotion of demand and increased utilization of RMNCAH services should include strategies for reducing patient congestions in health facilities. Some of the measures for this challenge might be local and specific to a particular facility; hence, it is difficult to generalize, but important to consider. Findings from the evaluation showed that women complained about congestion, especially when attending ANC clinics.

- In some circumstances, the "would be" best outcomes of the project were impaired by factors that were beyond the control of the project. A good example is the issue of staff turnover/transfers. Despite the considerable investment to provide training to different cadres of service providers working on RMNCAH services, some were removed from their positions because of the countrywide academic certificate authentication exercise, transferred, or promoted to other positions, which meant they were no longer providing the required services. In the future, agreements with district councils on staff who received the training investment from projects/programs can be used to mitigate the turnover challenge.

**Learning from Equity and Gender Analysis**

Key lessons learned from UNICEF’s efforts to ensure equity and gender in the project reveal that there were many successes in increasing access, usage, and quality as a result of having a strategic lens focused on equity and gender.

- The project benefitted **incorporating activities that involved males** in the delivery of care to pregnant women and girls and contributed to ensuring gender equity in community outreach activities.

- A key lesson learned from the findings of the establishment of AFRH services is that beyond the availability of these customized health services, **there is a need for increased awareness among**

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51 Interventions included improving facility readiness by ensuring availability of BEmONC and CEmONC signal functions, training, introducing Kangaroo Mother Care practices, use of partograph, promoting ANC, facility delivery services, postpartum and postnatal care, Infrastructure and equipment improvement, Adolescent-Friendly Reproductive Health Services, supportive supervision from Council Health Management Team (CHMT), maternal and Perinatal Death Reviews, Quality Improvement Teams, Referral System.
adolescent pregnant girls that AFRH services exist at the health facilities covered by the project. There is also an increased training need for HCWs around improving their attitudes about adolescent pregnancy so they can better serve the girls’ needs.

- **By targeting rural women, the project was impacted by external factors beyond its scope.** For instance, women lacking mobile phones, weak road infrastructure, as well as inhibiting social and cultural norms, including having to stay home due to household chores and parental attitudes, prevented some women and girls from participating in community outreach efforts.

- The project contributed to incorporating an equity and gender lens in partnership with the GoT’s national efforts. Specifically, the main focus was on MNCH and AFRH services, which resulted in improving access and utilization of these services among those in rural areas, uneducated women, and adolescent girls. A key lesson learned from the findings indicates that **equity stretches beyond the populations that were reached. Therefore, there were limited findings of the experiences of women and girls facing disabilities.**

- **UNICEF should conduct vulnerability mapping during the design stage of any project to determine the most vulnerable and hard-to-reach women and girls.** To strengthen the equity, gender, and human rights-based approach, mapping should be led by UNICEF, in collaboration with the MOHCDGEC, to ensure the most marginalized and excluded populations are accurately identified. It will permit the design of interventions to target the most rural women and girls, those facing disabilities, unmarried women and adolescent pregnant girls, HIV-positive adolescents, and women and girls without mobile access.