Zanzibar

Afya Bora ya Mama na Mtoto Project (2015-2019)

Final Evaluation

Final Report

7 September 2020

development solutions

*Afya Bora ya Mama na Mtoto means Good Health for the Mother and Baby

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The views and opinions expressed in this report are of the independent evaluation team and do not represent the position of UNICEF Tanzania, UNFPA Tanzania, the Revolutionary Government of Zanzibar and the Government of Canada.

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Acronyms

ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive health
AYS	Adolescent and Youth Friendly Services
BEmONC	Basic Emergency Obstetrics and Newborn Care
CBOs	Community Based Organisations
CEmONC	Comprehensive Emergency Obstetrics and Newborn Care
CHMT	Council Health Management Team
CHV	Community Health Volunteer
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
DHIS	District Health Information System
DFATD	Department of Foreign Affairs Trade and Development
DMO	District Medical Officer
EmONC	Emergency Obstetrics and Newborn Care
ENC	Essential Newborn care
EPI	Extended Programme on Immunization
ERG	Evaluation Reference Group
FANC	Focussed Antenatal Care
FP	Family Planning
GAC	Global Affairs Canada
GEROS	Global Evaluation Report Oversight System
HCP	Health Care Provider
HCW	Health Care Worker
HF	Health Facility
HMIS	Health Management Information System
HPU	Health Promotion Unit
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSSP	Health Sector Strategic Plan
IEC/BCC	Information, Education Communication/Behaviour Change Communication
IMCI	Integrated Management of Childhood Illnesses
IRCH	Integrated Reproductive and Child Health
IRCHP	Integrated Reproductive and Child Health Programme
IRCHS	Integrated Reproductive and Child Health Services
ISS	Integrated Supportive Supervision
MCH	Maternal and Child Health
MMR	Maternal Mortality Ratio
RMNCAH	Reproductive Maternal New-born and Child Health
MOHZ	Ministry of Health (Zanzibar)
MPDSR	Maternal and Perinatal Death Surveillance and Review
NGOs	Non-Governmental Organisations
OECD	Organisation for Economic Cooperation and Development
PHCU+	Primary Health Care Unit+
PHCC	Primary Health care Centre
PNC	Post Natal Care
QI	Quality Improvement
RGOZ	Revolutionary Government of Zanzibar
RMNCAH	Reproductive, Maternal New-born and Child and Adolescent Health

SBCC	Social Behaviour Change Communication
SDGs	Sustainable Development Goals
SUZA	State University of Zanzibar
TDHS	Tanzania Demographic and Health Survey
TFR	Total Fertility Rate
U5	Children Under the age of 5 years
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
ZFPP	Zanzibar Family Planning Programme
ZHRI	Zanzibar Health Research Institute
ZNBTS	Zanzibar National Blood Transfusion Service
ZSGRP II	Zanzibar Strategy for Growth and Reduction of Poverty

Executive Summary

Project description

The Afya Bora ya Mama na Mtoto project was implemented from March 2015 to October 2019 It was designed to address maternal and child mortality, and in addition, improve the overall health and well-being for mothers and children in Zanzibar. The project targeted 75,000 pregnant women, 130,000 mothers/caregivers of children 0-59 months, 260,000 children 0-59 months and 130,000 adolescents covering all areas of Zanzibar. The project was funded by the Government of Canada to the tune of 15 million Canadian dollars. It was a UN joint programme between UNICEF/UNFPA and the Revolutionary Government of Zanzibar with Save the Children as the contracted NGO to facilitate implementation of the community health component.

The main objective of the project was improved health and wellbeing of women and children in Zanzibar. This was supported by two overarching objectives that sought to:

1) strengthen and ensure the health system delivers equitable and integrated health services including improvements in the referral system, and
2) increase coverage of quality emergency obstetric, new-born and child health services, including high impact nutrition interventions.

The project interventions included: recruitment and establishment of community health volunteers (CHVs), upgrading selected primary health care units to provide BEmONC services including building or renovating infrastructure, purchase of equipment, and skilling health care workers (HCWs); short, medium and long term training for various RMNCAH services, support pre-service training, supporting district level health system management, and strengthening monitoring of RMNCAH outcomes (Human Resources for Health information system, Star Rating, Maternal and Perinatal Death Surveillance and Response (MPDSR)).

Evaluation objectives and intended audience

The primary focus of the evaluation was to generate substantive evidence and lessons learned on the relevance, effectiveness, efficiency, sustainability, gender and equity focus of the Afya Bora project. The specific objectives of the evaluation were to:

1. Determine the relevance, effectiveness, efficiency, sustainability, gender and equity focus of the Afya Bora ya Mama na Mtoto project;
2. Assess the integration of critical organizational principles and approaches, namely equity and gender in project planning, implementation, and monitoring; and
3. Document good practice, lessons learned and provide actionable recommendations for improved future anticipated project design, advocacy for scaling up as well as for the improvement of MoHZ strategies, Maternal, Newborn, Child and Adolescent Health (MNCAH) and Reproductive Health Plan of Zanzibar.

The main audience of the evaluation are: 1) Government of Canada, 2) Headquarters of UNICEF and UNFPA; 3) UNICEF Eastern and Southern Africa Regional Office (ESARO), 3) UNFPA ESARO, 4) Tanzania and Zanzibar sub-offices of UNICEF and UNFPA, 5) Ministry of Health Zanzibar (National and district level including Council Health Management Teams (CHMTs) in Zanzibar, 7) Beneficiaries of the project (facilities, Community Health Volunteers (CHVs), communities), 8) Save the Children. This audience will be reached through an elaborate plan for results dissemination that will be designed and implemented by the two implementing UN agencies.

Methodology

Evaluation design: Because no baseline was undertaken by the project, the evaluation adopted a One-Shot Retrospective Design premised on recall during structured and qualitative surveys to reconstruct the baseline. Baseline for indicators available in the District Health Information System (DHIS2) was retrospectively developed to provide a "before" and "after" scenario.

The evaluation data collection covered both islands of Unguja and Pemba.

The United Nations Evaluation Group (UNEG) guidance on evaluation, human rights centred and gender responsive evaluation were adopted in the tools and data collection approaches. The UNICEF Global Evaluation Reports Oversight System (GEROS) was the main guidance on evaluation quality standards. Evaluation principles of independence, credibility, integrity, and inclusiveness were integral to the evaluation approach.

To enhance adherence to the principles of research involving human subjects, the evaluation sought and received ethical clearance from the Zanzibar Health Research Institute (ZHRI). These protocols, which included informed consent were central part of the data collection.

Data sources: The evaluation used multiple sources of data that provided secondary and primary data. Secondary data comprised quantitative data extracted from DHIS2, partner reports and health facility records. Primary data comprised qualitative data from key informant interviews and focus group discussions with a cross section of the project stakeholders. Key informant interviews were held at national and district level with MOHZ staff (Nutrition department, Health Promotion Unit), focal personnel from UNFPA, UNICEF and Save the Children, Zanzibar College of Health Sciences, and the Zanzibar National Blood Transfusion Service (ZNBTS). Focus group discussions were undertaken with Community Health Management Teams (CHMTs) in the visited districts, Community Health Volunteers (CHVs) and their supervisors, adolescent girls and boys, men above 25 years, and women above 25 years who had children under five years. Discussions were also held with trained health workers in selected facilities receiving support from Afya Bora and with facility in charges.

For inclusivity and diversity, the selection of districts considered a mix of available health facilities supported under the project to cover for renovated Primary Health Care Units+ (PHCU+)[1], non-renovated PHCU+, and hospitals including the central hospital. The selection also considered a mix of both urban-based and rural-based districts. The selected districts represented 36 per cent of the total districts of the two islands of Zanzibar. Seven facilities comprising four PHCU+, two district hospitals, and the central hospital (Mnazi Mmoja Hospital) were visited for the evaluation.

Data collection and analysis: The evaluation team members led data collection at national and district level. Two experienced research assistants assisted in collecting data at community and facility level. These assistants, who were recruited from Unguja Island of Zanzibar, had knowledge and prior experience with RMNCAH, and in undertaking research. They were trained on the specific tools for the evaluation before deployment in Pemba and Unguja. Data was analysed to show contribution of the project observed outcomes by first determining achievement of targets and second determining the causal chain. *Quantitative data:* secondary data analysis included before and after comparisons and trend analysis to determine points of divergence in data trends and how the project may have influenced that divergence. *Qualitative data:* all qualitative transcripts were transcribed in Microsoft Excel according to respondents, themes and questions to prepare for analysis. Atlas ti, a qualitative data analysis software, was then used to identify emerging themes from the data and the supporting quotations.

[1] The basic health care unit at the village level is Primary Health Care unit (PHCU). The next level is the Primary Health care Centre (PHCC or PHCU+). This is followed by the District hospital and the central hospital, Mnazi Mmoja referral hospital.

Validation and dissemination: The evaluation reference group reviewed the draft evaluation report to correct any factual errors. The results of the evaluation will be disseminated to all stakeholders by implementing partners.

Limitations of the evaluation:

1. **Unavailability of some stakeholders**: some stakeholders who had been listed in the interview schedule were unavailable during the field visits by the evaluation consultants. However, the impact of this was limited as the majority of stakeholders included in the original interview schedule were available..
2. **Limited visibility of Afya Bora at subnational level**: Afya Bora as a project was not visible at district and facility levels. It took probing to ensure stakeholders were talking about interventions supported by the Afya Bora. This had the risk of getting information on performance of other projects not Afya Bora. The impact of this was limited by ensuring we referred to interventions of Afya Bora, rather than the project name in cases where the confusion was great.
3. **Some indicators in the project's results framework had no baseline values or their data was not collected by the Zanzibar DHIS**. These indicators were excluded from the analysis of project performance. The full scope of the project's achievement could, therefore, not be ascertained. However, the proportion of these indicators was less than 20 per cent and therefore did not have a significant influence on the evaluation's findings as agreed in the Inception Report.

Findings

Relevance

- The Afya Bora Project was well aligned to the relevant national priorities, policies, and strategies; UNICEF and UNFPA global priorities; and Government of Canada global priorities. Nationally policies and strategies to which Afya bora was aligned included: Zanzibar Health Sector Strategic Plan III 2013/14-2018/19 (ZHSSPIII), Road Map Strategic Plan to Accelerate the Reduction of Maternal, New-born and Child Deaths and Adolescent Health (2015-2018) and the Strategy for Growth and Reduction of Poverty III, 2016-2020 (MKUZA III).
- The project demonstrated flexibility in project implementation through supporting decentralization and inclusion of missing elements during project implementation. This included reconfiguring the project to align with the implementation of decentralisation that came into effect in the third year of the project, addition of SRHR and male involvement, which were not part of the project design.
- Majority of causality linkages in the theory of change were plausible as majority of assumptions underpinning the theory of change of the project were valid, except for a few which became risks to project performance. These related to: 1) health facilities will fully utilise the new RMNCAH equipment provided even without additional training on its use; and that 2) new skills and knowledge for RMNCAH developed among HCWs will be utilised in their stations. In some instances, equipment was not provided with accompanying training leading to redundancy. In others such as in Wete district, the ultrasound machine was delivered at the district hospital, but there were no resources to ensure the ultra-sound team is mobile to reach all facilities. Staff transfers and task shifting also had an impact on knowledge and skills retention. Furthermore, general staff shortages were undermining delivery of improved RMNCAH services.

Effectiveness

- The project made significant achievements in meeting at least 50 per cent of its targets. The project was able to fully meet its targets in 19 out of 37 indicators (51.3 per cent), with satisfactory progress in 32.4 per cent of the targets[2]. Only 3.1 per cent of targets were off track whereas

[2] "Satisfactory progress" means indicators achieving 75-99 per cent of the target, while "off track" are indicators reaching less than 75 per cent of the target.

another 3.1 per cent of targets had no data available for verification[3]. This success has seen institutional maternal and neonatal deaths decreasing since 2015 with direct attribution to the project. Zanzibar institutional Maternal Mortality Ratio (MMR) went down from 277 per 100 000 live births in 2016 to 155 per 100 000 live births in 2018[4]. Health facility based early neonatal mortality rate has declined from 11.3 per 1 000 live births to 8.5 per 1 000 live births between 2017 and 2018[5].

- The successful deployment of community health volunteers in 10 out of 11 rural districts led to a significant increase in demand for RMNCAH services in Zanzibar, which in turn saw an increase in facility-based delivery and improvements in childcare and nutrition. As an example, facility-based deliveries increased from 34,563 in 2016 to 41 639 in 2018 and were 65.8 per cent of all deliveries compared to 56 per cent in 20156. CHVs were able to reach 152 194 children under five, 42 467 pregnant women, 108 238 caregivers, 64 632 adolescent girls and boys, and 26 717 influential leaders. All stakeholders interviewed agreed with the immense contribution of CHVs in creating demand for RMNCAH services in Zanzibar. Due to their successful contribution, CHVs were increasingly recognised as an effective mechanism for mobilising communities for MOHZ programmes – beyond their envisaged role.
- Improved infrastructure and availability of equipment supported provision of quality RMNCAH services. Support from the Afya Bora project to improve infrastructure and provide equipment for RMNCAH services at project sites was considered to be impactful in ensuring availability of and quality services. For instance, the theatre at Micheweni District Hospital was equipped by the project to be able to start providing caesarean section (C/S) services. Fuoni PHCU+ witnessed increased volume of RMNCAH clients following construction of the RCH and maternity building in 2017 and receipt of RMNCAH equipment under the project's support. Consequently, the number of deliveries increased by over 60 per cent between 2016 and 2018 at the Fuoni PHCU+.[7] Construction and/or renovation of incinerators and placenta pit enabled respective health facilities to improve IPC practices and hence the quality of care. In total, the project supported construction /refurbishment of 6 health facilities 3 each for Unguja and Pemba (Fuoni, Tumbatu, Sebleni, Uondwe, Junguni and Bogoa), most of these facilities are in rural areas therefore their construction has contributed in increased community access to care. Beneficiaries of the support commended the appropriateness and quality of both infrastructure and equipment under Afya Bora. Nevertheless, it was found that not all equipments distributed to health facilities were immediately put to use with some still unpacked at the time of the evaluation where lack of skills to assemble or use the equipment was given as one of the reasons.
- Support to the Zanzibar National Blood Transfusion Service (ZNBTS or Blood Bank) led to a significant increase in life saving blood donations and blood components, resulting in 95 per cent of blood requests being met in 2018. The project resolved challenges faced by the ZNBTS which included: 1) limited capacity for community mobilisation for blood collection; and 2) non-availability of blood components and compatibility tests. For the former, the project managed to facilitate establishment of a working relationship between the ZNBTS and local governments resulting in local governments leading mobilisation for blood collection and contributing to payment of incentives for blood donors.
- Training of Health Care Workers in various technical areas improved their competencies and confidence in providing quality RMNCAH and Nutrition services. Trainings covered competencies around ANC, BEmONC, CEmONC, Essential Newborn Care, Kangaroo Mother Care, Nutrition and youth friendly services. A total of 1090 HCWs received short-term training and 42 HCWs received medium and long-term trainings, which resulted in improved performance in the delivery of

[3] Because either the data was not collected in the DHIS or was not being collected at the onset of the project.
[4] Zanzibar Health Bulletin, MoH, 2018.
[5] Source: Afya Bora ya Mama na Mtoto Final Report, 2020.
[6] Source: DHIS2 (Accessed in February 2020)
[7] See Afya Bora ya Mama na Mtoto Annual Report (1 May 2018 – 30 April 2019)

RMNCAH and Nutrition services. For instance, following training for HCWs by the project, Kivunge District Hospital initiated provision of C/S services. At the beginning of the project, the hospital had an operating theatre but there were no skilled personnel to conduct surgeries. With implementation of a mentorship program, which included introduction of two roving obstetricians, the project trained health care workers got confidence to use their newly learned skills. Further long term training for nurse/midwifery tutors for post graduate degrees coupled with the revisions to the nursing and midwifery curriculum contributed to improved pre-service training. Prior to the project Zanzibar had only one obstetrician gynaecologist and following Afya Bora investment in long term training, Zanzibar had a total of 6 obstetrician gynaecologists at the time of the evaluation. The mentorship programme for C/S and task shitting for CEmONC had profound effects in enabling provision of service. All staff remained in post at the time of the evaluation.

- Project coordination and monitoring system was established in collaboration with the MOH Zanzibar which facilitated ownership of project interventions at national level. However, there were challenges with adequacy of data sources for all indicators and visibility of the project at lower levels.
- Afya Bora is recognized for quality and technical excellence. The setup of the project implementation team that included UNICEF, UNFPA and Save the Children as a sub-contracted NGO seems to have worked very well in successfully implementing the project. Testimonies and feedback from stakeholders and beneficiaries were generally positive regarding the quality of support received from Afya Bora.
- Awareness of the project's brand diminishes at sub-national level. It was challenging during the evaluation field mission in the districts to directly associate project's achievement and/or support with the project "Afya Bora". In a few instances, some stakeholders were only able to recognize support from the project by identifying individual project officers whom they usually met during implementation.

Equity and gender focus

- Support to health facilities ensured the neediest of facilities were targeted by the project. However, equity in service provision is still a significant challenge in Zanzibar with Pemba facilities being more affected than those in Unguja. This is reflected in all services. For instance, blood products are only available in Unguja where the project procured refrigerated centrifuge is located. Pemba still receives only whole blood and is unable to prepare paediatric packs and platelets. Although they receive the latter as per need, there are sometimes supply breaks. Poorer service delivery in Pemba is reflected in the progress in perinatal deaths, home deliveries and other RMNCAH outcomes. For example, data shows increased stillbirth rate by 28 per cent from 21.3 deaths per 1 000 births to 27.3 deaths per 1 000 births in Pemba compared to only 8.5 per cent increase in Unguja (from 18.8 to 20.4 deaths per 1000 births between 2017 and 20188.
- The project could have increased investment in Pemba to increase availability of: 1) quality BEmONC services especially in remote islands; and 2) blood components and other services to support CEmONC.
- During implementation, the project included male champions in the CHV component. Deliberate effort to engage traditional and religious leaders (who are mostly men) was made and ensured messaging during community mobilisation encouraged male involvement in reproductive health and childcare. While this is commendable, the project could have benefited from a systematic approach to addressing gender, ensuring that gender inclusion was premised on a sound gender analysis of the project components.

Efficiency

[8] Source: DHIS2

- An effective national coordination framework for the project was established and was functional. The project was embedded in MOHZ coordination structures at national level with Afya Bora as a standing agenda in the RMNCAH Technical Working Group (TWG). This approach represents good practice for building and strengthening existing mechanisms for MOHZ in low resource contexts.
- Coordination of Afya Bora at national level represents good practice for UN joint programmes. There was clear division of labour between the agencies, and by operating in the same facilities and communities they were able to bring comprehensive support at the facility and community level that neither agency would have provided alone.
- RMNCAH coordination at district level was improved, but district coordination of Afya Bora was weak and needed to be improved to enhance transparency and accountability at this level, serve for the CHV component which held quarterly meetings with CHV supervisors and CHMTs. To enhance Afya bora coordination and participation of district level staff in planning Afya Bora activities, the project should have been a standing agenda point in the CHMT meetings.
- The project worked with the existing health information system to monitor project performance, albeit with some concerns on data quality. Use of existing systems is commendable and has the potential to contribute to strengthening these systems. However, there were inherent data quality issues right from the facility level. Some project indicators could not be informed with the available data from national health information systems. While the Afya Bora revitalised the HRH information systems it was still at early stages of implementation at the time of the evaluation and data on human resource for health was not readily available.
- Strengthening of the Maternal and Perinatal Death Surveillance and Response (MPDSR) had a significant contribution to the improvement of RMNCAH service delivery. At Zonal, district and health facility levels, MPDSR teams were established and remained functional. The teams were meeting to discuss maternal and perinatal deaths that happened in their areas and together came up with implementable recommendations to prevent future deaths from similar cause. Monitoring implementation of recommendations of the MPDSR was still weak and undermining its effectiveness.
- Facility assessment and accreditation (Star Rating) not only led to improvements in availability of a minimum package of integrated RMNCAH services, but also enabled the project to determine progress in availability of services at health facilities.
- Whilst Afya Bora has successfully achieved 51 per cent of its targets and made progress towards others, this has been possible because of the operational staff, the health workers and community health volunteers at the facility levels. There is potential to achieve more with levels of staff increased and their skills and competences enhanced.
- Project staffing in implementing partners may have been inadequate for the scale of the project. It was evident that staff from both, MOHZ and Save the Children, had strong commitment to the project, but were overwhelmed by the scale of the project. The project had one focal person in MOHZ who was also responsible for other activities within the ministry. The demands of Afya Bora and those of MOHZ overstretched existing staff leading to delays in some cases.

<u>Sustainability</u>

- The Revolutionary Government of Zanzibar and its agencies appreciate best practices from Afya Bora project and intend to continue supporting them.
- The project built capacity at service delivery sites to sustain RMNCAH and Nutrition services. The project's approach highlights how capacity development can be transformative by changing practices in a positive way. For instance, all providers that were supported for medium and long term trainings came back to work for the MOHZ with 95 per cent of them still doing clinical work[9].

[9] Source: Health Facility Assessment Tool.

- Evidence gathered during interviews demonstrates that officers at both national and sub-national levels are still in transition regarding understanding and implementing the decentralized system. Lack of clarity of roles and weak coordination of actors at various levels may undermine efforts to sustain the gains in RMNCAH and Nutrition services.
- Financial constraints have had impact on implementation and oversight of RMNCAH services. The major concern on sustainability from almost all stakeholders interviewed was on availability of financial resources. There was no clear exit strategy on how the Government of Zanzibar will be taking over project-sponsored activities after Afya Bora ends. However, the government has made a noble decision to institutionalise and integrate some of the interventions of Afya Bora. These include Star Rating, Bottleneck analysis, and MPDSR into DHIS2 and nutrition commodities into the logistics management system. The project supported infrastructure guidelines will continue to impact positively on the health sector after the project. Some initiatives, for example, had already "stopped" after Afya Bora with examples being mobile phone support on emergency referrals, Kangaroo Mother Care (KMC) evaluation meetings and HCW post training follow up.
- Staff who underwent medium to long term training have remained in the employment of MOHZ and are providing RMNCAH services. This is mainly due the agreement made prior to the training between UNFPA, MOHZ and individual health staff to be bonded for a specified period after training.
- This has not featured well above and also needs a recommendation for retaining the staff.
- The use and involvement of District and Regional Level leaders in activities such as mobilising blood donors had a positive lasting impact to the continuation of services beyond the project lifespan. However, inadequate involvement of some local stakeholders in critical stages of the project may undermine ownership and sustainability of project-supported activities. Stakeholders at district and facility levels also acknowledged being part of the project, but mainly during implementation of activities. There were universal concerns regarding participation of district health managers and health facility leaders in the design of the project, prioritization and planning of project activities in their local sites.
- Limited availability and operationalisation of updated policies, strategies and protocols in RMNCAH at facility level will undermine sustainability of quality in RMNCAH services.

Conclusion

Afya Bora was a successful project that improved RMNCAH outcomes in Zanzibar including reducing maternal and neonatal deaths. The ability of the UN agencies to jointly plan and complement each other in implementing activities provides evidence of good practice in UN joint programming. The project was embedded in and was driven by the MOH in Zanzibar leading to ownership of its interventions at national level. This in turn led to institutionalisation of some of the project's interventions. This approach was successful, despite capacity weaknesses within the MOHZ. Further supporting the success of the project was an appropriately designed project that had a sound understanding of the multi-dimensional challenges underpinning poor RMNCAH outcomes for Zanzibar. However, several areas needed to be improved including: 1) enhancing equity and gender responsiveness of interventions; 2) monitoring and district level ownership; 3) ensuring there was a shared understanding of the exit strategy for the project.

Recommendations

Below is a summary of the recommendations from the evaluation. The detailed recommendations are presented in section 5.3.

- **Recommendation 1:** Build a strong health information system to lay the foundation for evidence based health sector planning. **Responsibility: MOHZ**
- **Recommendation 2:** Establish a well-coordinated system for selection of health workers for short term training which enhances value for money. **Responsibility: MOHZ**

- **Recommendation 3:** Maintain minimum standards of care by ensuring availability of national guidelines and protocols at health facility level. **Responsibility: MOHZ**
- **Recommendation 4:** Strengthen the referral system to support provision of quality care at all levels. **Responsibility: MOHZ**
- **Recommendation 5:** Put in place a system that incentivizes remote placement to achieve equity in quality of service delivery. **Responsibility: MOHZ**
- **Recommendation 6:** Scale up of CHVs with the new strategy should build on investment and gains from Afya Bora. **Responsibility: MOHZ**
- **Recommendation 7:** Put in place preventive maintenance system to maintain equipment and buildings supported by Afya Bora. **Responsibility: MOHZ**
- **Recommendation 8:** Streamline roles between MOHZ technical departments and CHMTs to ensure efficient coordination**. Responsibility: MOHZ**

1 Introduction

This report presents the Final Evaluation of Afya Bora ya Mama na Mtoto Project (2015-2019) and full details of its findings. We use Afya Bora throughout the report as a short form of the full project name.

2 Background

Project Context

2.1.1 Socio-economic context

Zanzibar is comprised of two islands, Unguja and Pemba, and several other smaller islands, located in the Indian Ocean. Zanzibar Islands and the Tanzania Mainland constitute a union of countries called the United Republic of Tanzania. The population of Zanzibar was 1.5 million people according to a 2016/17 population projection estimate: Unguja population was 1.1 million and Pemba 0.4 million. Estimates show that the sex ratio is almost 1 to 1 with 731,256 males and 780,977 females.[10] According to the Basic Demographic and Socio-Economic Profile Report 2014, the population in Zanzibar is youthful with 42.5 per cent below the age of 14 and 34.3 per cent between the ages of 15 and 34 (Figure 1). The population of Zanzibar is pyramid-shaped with a broader base of young people and a narrow tapering apex of dependent elderly, typical of sub-Saharan Africa and of most developing countries. The high proportion of young people tallies with the large percentage of women of reproductive age (15 to 49 years) reported in 2014 to be 48.3 per cent. This correlates with a stagnated total fertility rate (TFR) that hasn't declined for almost 15 years: 5.3 in 2005 and 5.1 in 2010 and 2016.[11]

As 2014, Zanzibar was a low-income country with an annual per capita income of US$ 936[12]. However, with a 5-year average per capita income growth rate of 6.5 per cent, it is estimated to be a Lower Middle Income Country (LMIC). Despite this impressive economic growth, a World Bank assessment of data from the Revolutionary Government of Zanzibar's Household Budget Survey (HBS) and Integrated Labour Force Survey (ILFS) shows some disparities between the more urban island of Unguja and Pemba. The basic needs poverty rate stood at 30.4 per cent in 2015 when the assessment was conducted, compared to 34.9 per cent in 2010. In Pemba, it shows that the poverty rate increased from 48 per cent to 55 per cent between 2010 and 2015. Eighty-three per cent of Pemba's population resides in rural areas, suggesting that the underdevelopment of the island's urban sector was the main factor for the increase[13]. About 95 per cent of the population lived within 5km radius of a health facility.

In Zanzibar society, traditional gender-based roles mean that women, young women in particular, rarely have control over the decisions surrounding their own health care or that of their children. Husbands, mothers, mothers-in-law and traditional birth attendants all have significant influence on the type of health care that a young woman and her children will receive. There are also many deterrents to women seeking health services, including transport availability and cost, hidden costs and informal charges at the health facility, lack of privacy especially for delivery of babies, and disrespectful treatment by health workers. There is a limited knowledge among families and

[10] Population and Housing Census 2012 and Population Projections.

[11] Tanzania Demographic and Health Survey (TDHS) 2004/05, TDHS 2010 and Tanzania Demographic and Health Survey and Malaria Indicator Survey (TDHS-MIS) 2015/16.

[12] https://www.unicef.org/tanzania/media/1336/file/UNICEF-Zanzibar-2018-National-Budget-Brief.pdf

[13] Belghith,Nadia Belhaj Hassine; De Boisseson,Pierre Marie Antoine.2017. *Zanzibar poverty assessment (English).* . Washington, D.C. : World Bank Group. http://documents.worldbank.org/curated/en/778051509021699937/Zanzibar-poverty-assessment

communities on appropriate practices around maternal, newborn and child health and nutrition, as well as on hygiene and sanitation. Women may receive information at antenatal care and under-five clinic visits, but their opinion is rarely taken into account by influential family members at home. Nutrition related behaviours such as exclusive breast feeding for six months, adequate food frequency and diversity remain key challenges.

2.1.2 Status of RMNCAH

Prior to the initiation of the Afya Bora project in 2015, the maternal and child health status in Zanzibar was poor. These included, but not limited to: 1) low contraceptive prevalence rate of 12.4%; 2) high unmet need for family planning which stood at 35%; 3) the Maternal Mortality Ratio (MMR) was 276 deaths per 100 000 live births in 2016; 4) and the Neonatal Mortality Rate of 28 per 1 000 live births (MOHZ, 2016). The MOHZ and project reports show that only 27.7 per cent of pregnant women made four or more antenatal visits in 2015. The under-five mortality rate was 56 per 1 000 live births in 2015 (TDHS 2015/16). Malnutrition – stunting in particular – was also a major underlying cause of child mortality, was at 24 per cent in 2015.

A significant rate of decline of the Infant Mortality Rate (IMR) had been observed, but not with MMR. This was revealed during the review of the then, Zanzibar Health Strategic Plan II (ZHRSP II), which was coming to an end in 2014. Other observations were a weak human resource base in terms of quantity and quality of skilled staff. The proportion of skilled health personnel providing quality essential health care package services, with particular reference to primary care level, stood at 60%. Other significant factors were improper resource allocation, poor retention and motivation, inadequate and malfunctioning of the referral system and weak District Health Management Teams (DHMTs) were also some of the key challenges that were prevalent.

It is evident that the Revolutionary Government of Zanzibar is indeed fully committed to addressing all the observed problems and in particular to accelerate the reduction of maternal, new-born, child and adolescent morbidity and mortality in Zanzibar as evidenced through its 2011 health policy, strategies and other documents that include:

a) Strategy for Growth and Reduction of Poverty (ZSGRP II) 2010-2015,
b) Health Sector Strategic Plan III,
c) Road Map Strategic Plan to Accelerate the Reduction of Maternal, New-born and Child Deaths and Adolescent health in Zanzibar, 2008-2015 and One Plan.

This commitment is also strongly expressed in the Zanzibar Reproductive, Maternal, New-born, Child and Adolescent Health Strategic Plan (2019-2023) which was recently prepared in recognition of the achievements and challenges faced in that endeavour in the past. On the other hand, this is also supported by its partners including UNICEF and UNFPA. It is acknowledged that partners such as UNICEF and UNFPA have helped reduce mortality all over the world, by working to reach the most vulnerable children and mothers respectively everywhere in the world − Zanzibar is not an exception. The Afya Bora ya Mama na Mtoto (“A better health for mother and child”) project, launched in 2015, aimed at further improving the health and wellbeing of mothers and children.

Project Description

The Afya Bora ya Mama na Mtoto project was launched in 2015 and designed to address maternal and child mortality as well as improve health and overall well-being for mothers and children in Zanzibar. The project targeted the following in Zanzibar:

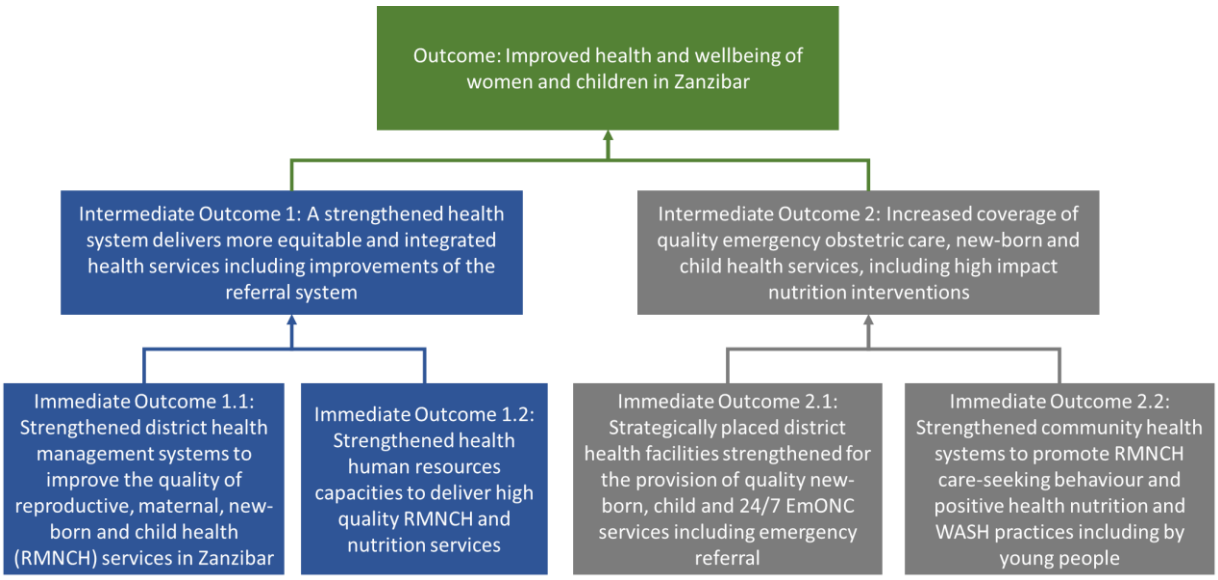
- 75,000 Pregnant Women
- 130,000 Caregivers of Children 0-59 months
- 260,000 Children 0- 59 months
- 130,000 Adolescents

The project was funded by the Government of Canada to the tune of 15 million Canadian dollars. It was a UN joint programme between UNICEF, UNFPA and the Revolutionary Government of Zanzibar with Save the Children as the contracted NGO to facilitate implementation of the community health component. Figure 1 provides the results chain of the project as depicted from the project design document. The project addressed health systems management and coordination, quality health service delivery for RMNCAH services and high quality nutrition interventions. The main outcome of the project was improved health and wellbeing of women and children in Zanzibar. This was supported by two overarching objectives that sought to:

1. Strengthen and ensure the health system delivers equitable and integrated health services including improvements in the referral system, and
2. Increase coverage of quality emergency obstetrics, new-born and child health services, including high impact nutrition interventions.

Coverage was increased by ensuring strategic facilities are "service ready" (offering quality new-born, child and 24/7 EmONC services including emergency referral) and strengthening community health systems to promote RMNCAH Care-seeking behaviour and positive health, nutrition and WASH practices.

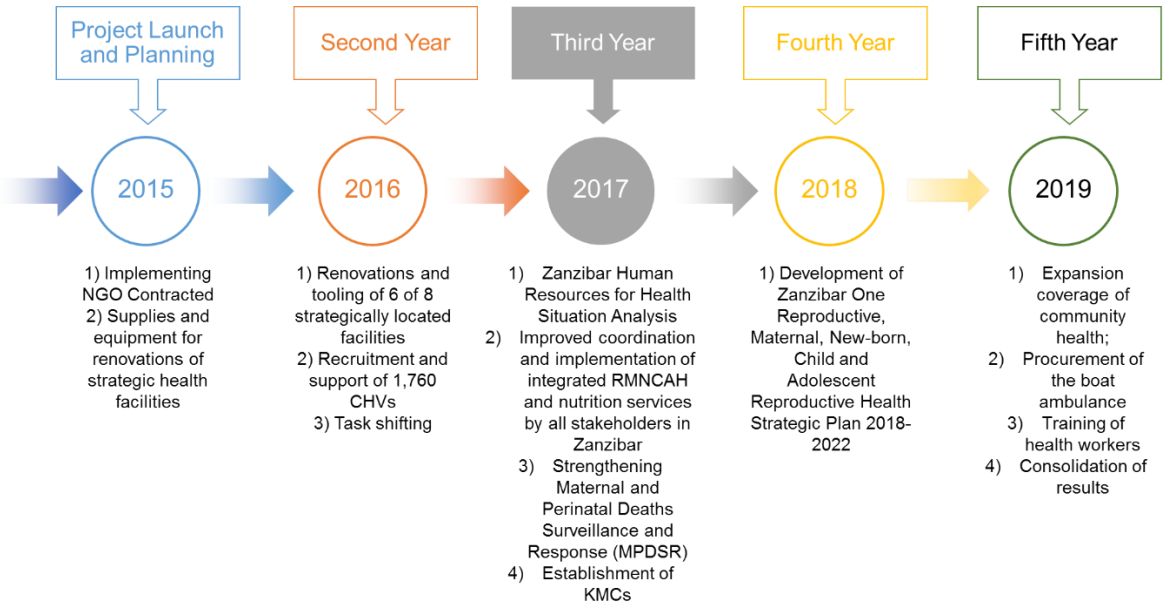
Figure 1: Anticipated results of the Afya Bora ya Mama na Mtoto project



Source: Project Proposal to Canada - Department of Foreign Affairs, Trade and Development

The project was implemented from March 2015 to October 2019. Key interventions and the chronology of implementation is presented in Figure 2.

Figure 2: Chronology of implementation of major activities of the project



Source: Annual Progress Reports

Project Theory of Change

A theory of change (TOC) was not part of the project design document. To fully map out the change trajectory required to address maternal, neonatal and child mortality in Zanzibar, the evaluation team undertook construction of a TOC. The process began with the development of a Problem Tree to understand the core problem that the programme sought to address as well as identifying the immediate and secondary causal factors. Included in the process were literature review, scoping interviews with key implementers and validation with the project's stakeholders in Zanzibar. This process was conducted during an inception workshop. Figure 3 provides an illustration of the problem tree. Both, supply and demand side constraints were observed to lead to high maternal, new-born and child mortality. Contextual factors which include underfunding, inadequate equipment and infrastructure, a poor human resources for Health (HRH) performance management system, weaknesses in planning and delivery of social behaviour change communication (SBCC) and poor linkage between community health system and the district health system were identified as the main secondary causes. On the demand side, limited support for community health volunteers, and inadequate attention to SBCC lead to continuation of:

1. limited knowledge among families and communities on appropriate practices around maternal, new-born and child health and nutrition and WASH; and
2. a patriarchal and cultural system that limits male involvement and support in RMNCAH care, relegating women's role in decisions on maternal care and delivery. Thus, limiting their health seeking behaviour.

Resultantly, this generates a low maternal health seeking behaviour, poor WASH and child nutrition/feeding practices, and low family planning usage. High cost of care, especially when referral is involved, contributes to these outcomes leading to increased acute malnutrition and WASH related morbidity among children and birth complications. Consequently, this results in high neonatal, child and maternal deaths.

On the supply side, underfunding of RMNCAH and a weak HRH performance management system all contribute to:

- Limited numbers, quality and low motivation and productivity of health staff;
- Lack of appropriate equipment and maintenance and inadequate infrastructure;
- Lack of accurate data and information for evidence-based action leading to inadequate planning, management of RMNCAH; and
- Frequent stock-outs of essential medicines and commodities in public health facilities.

Because of the lack of resources at facility level it was noted, in the Afya Bora project document, that facilities exhibited poor level and quality of care, as per recommended clinical standards, as well as poor and inadequate management of maternal and new-born complications. This was contributing to high rates of obstetric emergencies and maternal, neonatal and child deaths.

Based on this the Theory of Change for Afya Bora was determined as:

> *"If community health services are strengthened with enhanced linkages with health facilities and the district health management system and that: 1) availability of appropriate equipment and supplies; 2) adequate and quality human resources in health facilities; 3) an effective information management system for RMNCAH and efficient service coordination and integration are put in place with all of this supported by government's increased resource allocation for RMNCAH THEN maternal, newborn and childcare will be improved and demand for RMNCAH services increased, leading to lower birth complications and maternal, newborn and child deaths.*

The TOC is presented in Figure 4. While the TOC was established retrospectively it was meant to understand the broadness of the programme not redefine its focus as described in section 2.2 and Figure 2. Table 1 provides details of the linkages between the immediate outcomes and intermediate outcomes and results in the Theory of Change.

Table 1: Link between programme objectives and TOC

Original result/ objective	Contributing results in TOC
Immediate Outcome 1.1: Strengthened district health management systems to improve the quality of reproductive, maternal, new-born and child health (RMNCH) services in Zanzibar	- Strengthened district health management system to provide quality and adequate RMNCAH services - Improved planning and management of RMNCAH - Improved availability of accurate data and information for evidence-based action - reduced frequency of stockouts of essential medicines and commodities - improved level of care in health facilities as per recommended clinical standards - Improved management of maternal and newborn complications
Immediate Outcome 1.2: Strengthened health human resources capacities to deliver high quality RMNCH and nutrition services	- strengthened capacity and retention of health workers to provide quality RMNCAH services - increased numbers, quality, motivation and productivity of health staff - improved level of care in health facilities as per recommended clinical standards - Improved management of maternal and newborn complications - Improved provision of youth friendly SRH services

Original result/ objective	Contributing results in TOC
Immediate Outcome 2.1: Strategically placed district health facilities strengthened for the provision of quality new-born, child and 24/7 EmONC services including emergency referral	- Renovations and equipping of health facilities for provision of quality EmONC services - improved level of care in health facilities as per recommended clinical standards - Improved management of maternal and newborn complications
Immediate Outcome 2.2: Strengthened community health systems to promote RMNCH care-seeking behaviour and positive health nutrition and WASH practices including by young people	- Increased capacity of the Health Promotion and Education Unit in MOHZ to provide sufficient technical support and coordinate SBCC interventions including Community Health Programme. - Strengthened community health system including linkages between the community health services provided by community health volunteers, the district health system and health facility staff. - improved knowledge among families and communities on appropriate practices around maternal, newborn and child health and nutrition and WASH. - changing attitudes with regards the patriarchal and cultural system that relegates women's role in decisions on maternal care and delivery.
Intermediate Outcome 1: A strengthened health system delivers more equitable and integrated health services including improvements of the referral system	- Increased contraceptive prevalence rate - Improved child nutrition practices - Improved WASH practices - Improved maternal, newborn and child health seeking behaviour
Intermediate Outcome 2: Increased coverage of quality emergency obstetric care, new-born and child health services, including high impact nutrition interventions	- improved level of care in health facilities as per recommended clinical standards - Improved management of maternal and newborn complications
Outcome: Improved health and wellbeing of women and children in Zanzibar	- Reduction in cases of acute malnutrition among under fives - Reduction in related WASH illnesses - Reduced rates of birth complications and obstetrics emergencies - Reduction in maternal, neonatal and child mortality

Assumptions underpinning the TOC are presented in Table 2.

Table 2: Assumptions of the Afya Bora TOC

Assumption	Effect
Demonstration and implementation of best practices will lead to eventual government ownership	Government increases resources for RMNCAH to support continuation services thereby enhancing the project effect
The right calibre of health professionals is trained and 1) are of adequate numbers to deliver quality service; 2) have sufficient institutional support to facilitate full utilisation of new skills and knowledge gained, and 3) will be and remain in post during the implementation period.	Will allow health staff to implement their new knowledge and skills efficiently and effectively.
CHVs will remain highly motivated and in post and deliver the full package of services – RMNCAH, WASH, and Nutrition.	Community mobilisation is sustained giving rise to changing attitudes and appropriate health seeking behaviour.
RMNCAH clients can meet the demand side cost of care	Demand service is realised as clients can access appropriate service.

Figure 3: Project problem tree

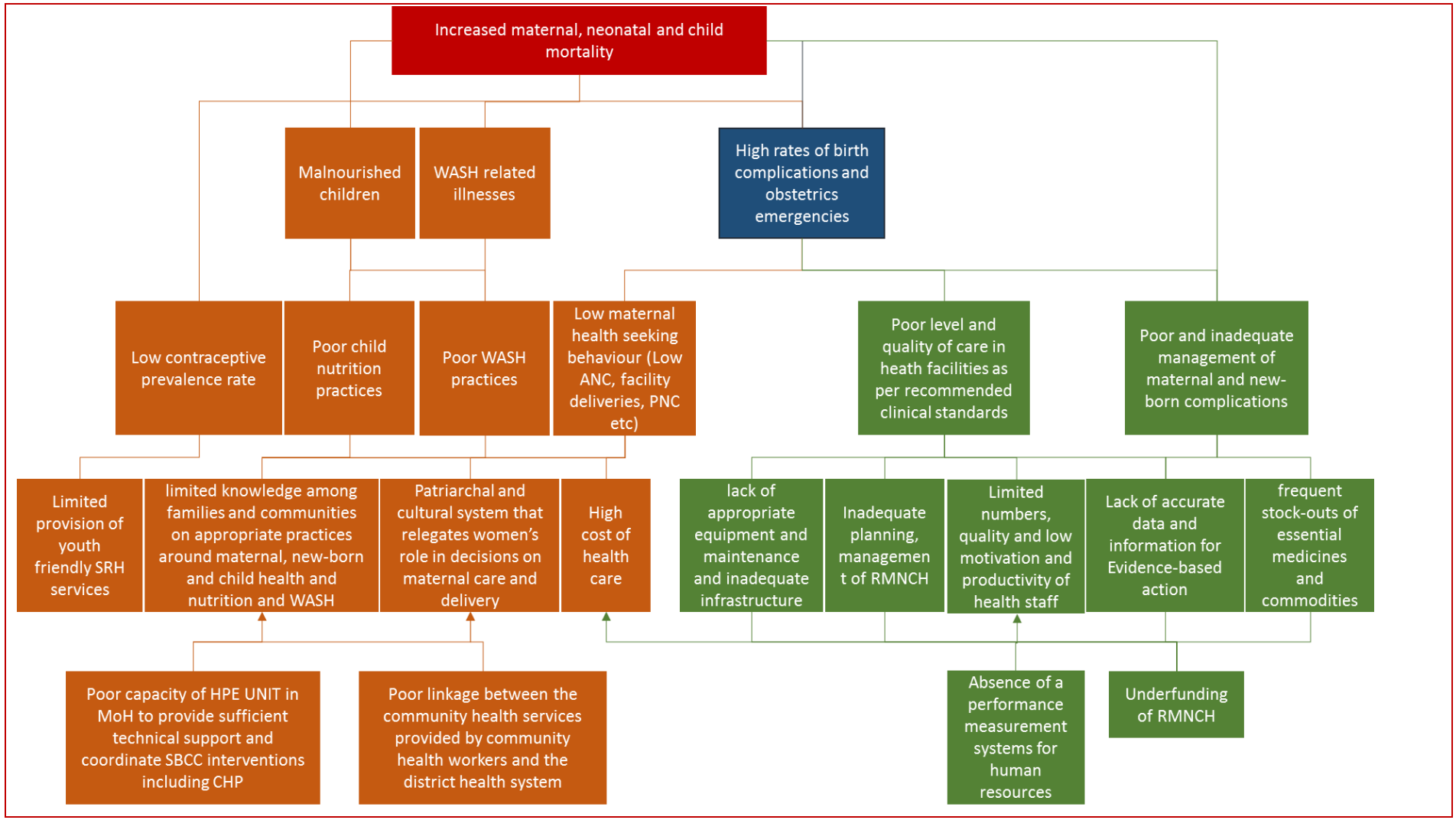
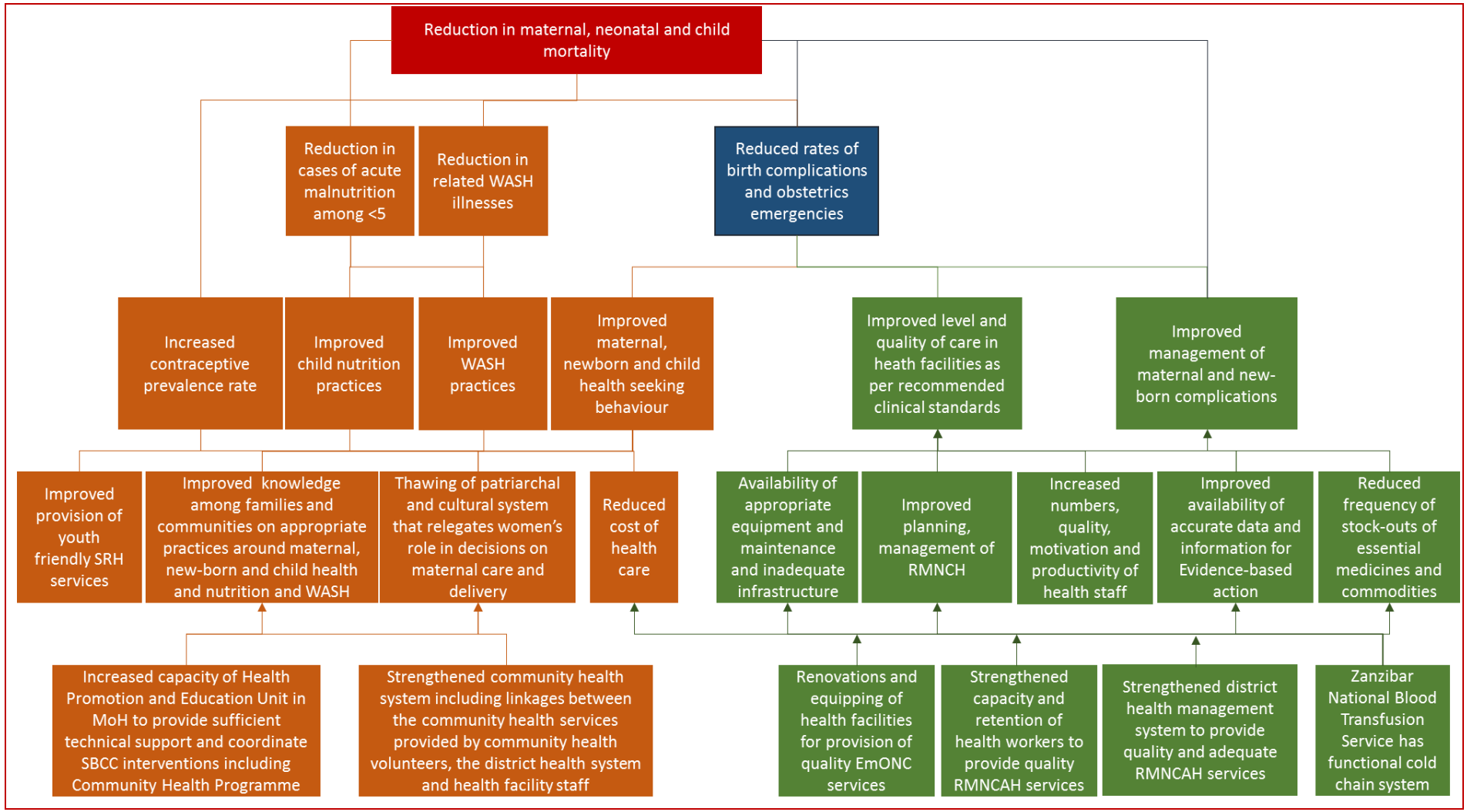


Figure 4: Theory of Change



Evaluation Purpose and Objectives

The primary focus of the evaluation was to generate substantive evidence and lessons learnt on the relevance, effectiveness, efficiency, sustainability, gender and equity focus of the Afya Bora project. Further, the evaluation findings and recommendations will be used to: strengthen future anticipated project design; to inform the nation-wide scaling up of the project, the end-term review of Zanzibar Health Sector Strategic Plan (2013/14-2018/19); and the 2020 mid-term review of Zanzibar One Reproductive, Maternal, Newborn, Child and Adolescent Reproductive Health Strategic Plan (2019-2023).

2.1.3 Evaluation objectives

The specific objectives of the evaluation were to:

1. Retrospectively develop the project's Theory of Change to enhance the project's evaluability;
2. Carry out an evaluability assessment of the project;
3. Determine the relevance, effectiveness, efficiency, sustainability, gender and equity focus of the Afya Bora ya Mama na Mtoto project;
4. Determine progress of the project in achieving its targets by establishing baseline for indicators in the results framework;
5. Assess the integration of critical organizational principles and approaches, namely equity and gender in project planning, implementation, and monitoring.
6. Document good practice, lessons learned and provide actionable recommendations for improved future anticipated project design, advocacy for scaling up as well as for the improvement of MOHZ strategies, MNCAH and Reproductive Health Plan of Zanzibar.

Evaluation Scope

Evaluation criteria and Questions: Table 3 provides the questions answered by the evaluation as provided in the Terms of Reference. They are organised according to four OECD evaluation criteria of: relevance, effectiveness, efficiency, and sustainability. Impact was left out of the evaluation, as based on the duration of actual implementation, impact level results would not be widespread at this time. A fifth criterion of equity and gender focus, was added to the evaluation to interrogate specific issues on equity and gender and respond to SDGs principles.

Table 3: Evaluation questions

Evaluation Criterion	Questions
Relevance	1. To what extent are the project design, results and implementation strategies relevant to the national and local context, strategies, policies and programmes?
Effectiveness	1. To what extent have the project's objectives and intended results been achieved? 2. What are the factors that facilitate or inhibit the achievement of the project's objectives and outcomes? 3. Which project activities had more significance to contribute to increased demand, coverage and uptake of quality emergency obstetric care, new-

Evaluation Criterion	Questions
	born, child and adolescent health services, including high impact nutrition interventions? 4. To what extent has the project addressed accountability and ownership of implementing partners? 5. How adequate have UNICEF's and UNFPA's support been to the project, including from the perspectives of different partners at national and subnational levels?
Efficiency	1. To what extent have the project management and coordination been efficient? 2. What was the quality of interventions implemented by the two agencies?
Sustainability	1. What are the enabling as well as constraining factors that influence the sustainability of the project? 2. What could or should be done differently in future replication and scaling up of the project? 3. How will good practices generated from the project be brought in and sustained at both national and sub-national levels? 4. What are the good practices and key conditions for national scaling up of the project?
Equity and gender focus	1. To what extent have the project design and interventions taken into account the most vulnerable and hard to reach populations? 2. To what extent have sex and disaggregated data been collected, monitored and analysed to inform the project?

Evaluation period: the evaluation covered the period from inception in 2015 to project end on 30 November 2019. However, for data related to the Health Management Information System (HMIS), the baseline was for the period 1 January to 30 September 2019 while the end line was for the sum of the period January 2018 to 30 September 2019. Selection of 9 months of the calendar year instead of the normal 12 as per the Ministry of Health's reporting cycle is due to the evaluation being undertaken in November, which precludes a full cycle assessment. Further details on this are contained in the inception report.

The evaluation covered both Unguja and Pemba islands targeted by the project.

Audience of the Evaluation and Uses

The main audience of the evaluation and their roles during implementation are provided below:

Table 4: Evaluation users

Audience	Interest in the evaluation	Role in project implementation
Government of Canada	Performance of the project Lessons learned for future similar projects	Funder
UNICEF and UNFPA Global	Lessons learned and best practices for design and implementation of similar projects	No specific role –guidance framework for RMNCAH interventions

Audience	Interest in the evaluation	Role in project implementation
UNICEF Eastern and Southern Africa Regional Office UNFPA Eastern and Southern Africa Regional Office	Lessons learned for design and implementation of similar projects	No specific role
UNICEF and UNFPA Tanzania Head Office and Zanzibar sub-office	Performance of the project Recommendations for improving implementation Lessons learned for design and implementation of future similar projects	Technical support to MOHZ Direct implementation
Ministry of Health Zanzibar (National and district level)		Project implementation
CHMTs in Zanzibar		Project coordination Access to facilities Supervision support Project monitoring and oversight
Beneficiaries of the project (facilities, CHVs, communities)	Performance of the project	Project implementation

It was envisaged that the evaluation results will be used to:

a) To demonstrate effectiveness of high impact RMNCAH interventions in low income contexts;
b) Improve institutional framework to support delivery of the RMNCAH in Zanzibar; and
c) Generate knowledge among practitioners.

3 Methodology

Evaluation Design

Based on the evaluability assessment the evaluation adopted a One-shot Retrospective Design premised on a combination of recall and reconstruction of baseline, especially for intermediate outcome indicators. This analysis was undertaken for data that was provided through the district health information system (DHIS2) and implementing partners. Recalling the baseline situation during primary data collection was used as another method to reconstruct the baseline situation for different respondents. The evaluation therefore used qualitative and quantitative approaches. Multiple data sources were used to inform the evaluation in line with participants and stakeholders involved in the project's implementation.

Evaluation guidance: Guided by the interests of UNICEF in the TOR and general UNICEF evaluation requirements, the evaluation used the following UNEG guidance documents to frame methods:

a) UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluations (2014);
b) UNEG Ethical Guidelines for Evaluation (2008);
c) UNEG Norms and Standards for Evaluation (2016)
d) UNICEF Procedure for Ethical Standards in Research, Evaluation and Data Collection and Analysis (effective from 1st April, 2015); and
e) UNICEF-Adapted UNEG Evaluation Reports Standards– including the Global Evaluation Report Oversight System (GEROS).

Evaluation principles: Based on these guidance documents, the evaluation adopts the following principles:
Independence, impartiality and credibility: External third party evaluations are premised on impartiality, independence and credibility of findings. As external evaluators, the evaluation team had no interest in the outcome of the evaluation but more critically, to ensure that our whole approach is underpinned by independence from the project under assessment, its funders and its beneficiaries, which is a defining condition for a quality evaluation output. Therefore, the findings represent an independent opinion. The evaluation team has had no prior interaction with the project or interests during its implementation and there is therefore no conflict of interest.

To enhance credibility of findings, data collection and reporting was based on evidence obtained from the field. This evidence was triangulated between sources including a validation process with stakeholders of the project. Resolution of divergent perspectives was based on support of evidence from findings. Where points of disagreement arise, project staff were requested to respond through a management response.

Transparency and Communication: The review was conducted in a transparent manner ensuring that all stakeholders and beneficiaries understood the purpose and scope of the review process and were engaged and committed to the review's success. Lines of communication were kept open at all times and consultation with the evaluation team leader was regular.

Quality: The evaluation has ensured that the results are of a high-quality and based on comprehensive evidence-based methodology using a mix of qualitative and quantitative methods. The evaluation included participation of key stakeholders and beneficiaries availed a rich coalescence of relevant data. The strength of the evaluation team's analysis and assessment is based on asking the relevant questions, communicating with key stakeholders, and collecting the required information. It is also based on the extensive experience of the evaluation team to reach sound and justifiable conclusions

and recommendations that meet the needs of the evaluation's target audience. The structure and content of the report was strongly influenced by GEROS.

Inclusiveness: all categories of beneficiaries of the project contributed to the evaluation. As described in the methodology section, this took into cognisance, disaggregation of age and sex.

Fair power relations: duty bearers (MOHZ, health facility staff etc.) and rights holders (women beneficiaries) were interviewed. Care was taken to understand the power relations between the duty bearers and rights holders and its effect on project results. The evaluation team ensured no one voice was emphasised over others. Lastly, the evaluation team acknowledges that the status of an evaluator can bring overbearing power on those being interviewed resulting in biased responses. Note was taken of this in the methods – particularly using participatory methods that ensure the opinions of all participants are heard and noted.

Honesty and Integrity: All findings and conclusions were evidence based. Where evidence was inconclusive, this is highlighted in the findings.

Gender and human rights: gender and human rights were incorporated in the evaluation in various ways. First the evaluation methodology ensured rights holders and duty bearers were included in the process of data collection. Second, analysis of findings was undertaken with a human rights lens especially regarding access and utilisation of services. Third, the proposed data collection approach recognised the implications gender has in respect to women's inability to express themselves in the presence of men. With this dynamic in mind, separate group meetings were held between men and women. All data collected from primary and secondary data sources was sex disaggregated.

3.1.1 Evaluability assessment

A rapid evaluability assessment that focused on devising appropriate methods to improve the quality of the evaluation was undertaken during the design phase of the evaluation. The rapid evaluability assessment focused on two of the components of an evaluability assessment[14]: *evaluability in practice* which assesses availability of relevant information for the evaluation and data capacity management systems and *evaluability in principle*. *Evaluability in principle* was enhanced by retrospectively developing the TOC and accompanying assumptions. The main focus of the evaluability assessment was on the *evaluability in practice*. To achieve this the evaluation team reviewed all the indicators required to inform performance of the project as presented in the log frame. The review resulted in some indicators being changed, removed or alternative proxies being added. The results of this assessment are presented in Annex 9.

3.1.2 Evaluation framework

Based on the evaluation questions in the TOR and presented in Table 2, an evaluation framework was developed presented in Annex 2. The evaluation framework guided the development of tools for the evaluation and provided the lens through which the project was evaluated. A summary of the evaluation framework is presented below. More details on the explanation of the evaluation framework can be obtained from the inception report.

[14] Three dimensions are essential when undertaking an evaluability assessment. The 1- adequacy of the program design, including its clarity, coherence, feasibility and relevance, which is the *evaluability in principle*. The 2- availability of information, data capacity management system, which is the *evaluability in practice*. And the 3- *conduciveness of the context for the evaluation*, especially stakeholder's and key users' views and resources available

Relevance

Under relevance, the evaluation assessed the extent to which the programme was aligned to the national, local contexts strategies, policies and programmes. It determined the extent to which the project was aligned to the following: Zanzibar Health Sector Strategic Plan (2013/14– 2018/19), the Road Map Strategic Plan to Accelerate the Reduction of Maternal, New-born and Child Deaths and Adolescent Health (2015-2018), the Zanzibar One RMNCAH Strategic Plan (2018-2022), UNDAP II and MKUZA III outcomes. At the local level, the evaluation assessed to which extent the project was aligned to local government plans and programmes.

In addition to assessing relevance to local context, the evaluation determined how the project responded to global and country level priorities of UNICEF/UNFPA and for GAC through the DFTAD priorities.

Equity and Gender

Equity was assessed at three levels: The first level was determining the criteria used to select facilities and whether these provided the project the greatest opportunity to address maternal and child deaths. The second level was equity in financial investments answering the question, "Did the investments go where they were needed most?" The third level was concerned with outreach to communities, determining how those in hard to reach areas, living with disabilities, and adolescents were benefiting from the project's interventions. Gender was assessed from two perspectives: 1) how gender was mainstreamed in the design of the project and its implementation, including to what extent it was grounded on a gender analysis; and 2) how the project collected, monitored and analyzed sex disaggregated data to inform the project.

Effectiveness

The assessment of effectiveness determined the extent to which the project's objectives were achieved. In this assessment the evaluation team was guided by the project's log frame/results framework indicators for the outcome, intermediate outcome and immediate outcome results (as demonstrated earlier in the TOC and the results chain). Data to assess project achievement on set targets was obtained from secondary sources including: DHIS2 for Zanzibar; and monitoring reports for the project. Data from the DHIS2 informed indicators on Intermediate outcomes 1 and 2 and the outcome indicators. Only indicators that can be measured by data from the DHIS2 were measured as per discussion under evaluability assessment.

In addition to determining achievement of the project targets, the TOR required the evaluation to investigate factors that facilitated or inhibited the achievement of the project's objectives. First, the evaluation team carried out an in-depth qualitative assessment of the individual, community, organisational and institutional factors that supported achievement of these results. Second, using qualitative primary data and literature review, the evaluation determined the extent to which differences in implementation (if any) had a profound influence on the success of the project at different sites.

Efficiency

In evaluating efficiency, the TOR required the evaluation to answer the question: *"To what extent has the project management and coordination been efficient?"*. This was assessed by investigating the following issues:

1. Level of functionality and effectiveness of national and subnational coordination platforms;
2. Staffing levels vis a vis the project's scale and objectives;
3. Platforms that exist for lessons sharing between partners and the benefits accruing;

4. Monitoring systems put in place, their adequacy to provide information required for project management and how information from the monitoring system was used for project steering at all levels;
5. Key drivers and constraints to coherence and coordination

Sustainability

Evaluation of sustainability assessed sustainability of interventions and benefits accruing from the interventions in the short medium and long term. Factors that support or inhibit sustainability were assessed at the individual, organisational and institutional levels. Scalability of the project was a critical factor for determining sustainability. In line with this, the evaluation team reviewed the Financial and Technical feasibility for scalability. The evaluation also made recommendations on the key conditions for national scale up.

3.1.3 Ethical consideration

There were no major issues regarding the conduct of this evaluation, which was not an intervention. No risk was identified in participating in the study. So, the participants' safety was assured. All men, women and youth had an equal chance to participate except in situations where a certain group or individuals ought to have participated for an identifiable reason. However, all participants had to sign a consent form to show that they were willing participants in the evaluation and were not forced to participate or volunteer any information. The participants were asked to participate with their full knowledge, do so voluntarily and with full consciousness giving their consent to participate. The UNICEF Guidelines on Ethical Research Involving Children and the UNICEF AGORA course on Ethics in Evidence Generation was a reference in developing ethical standards for the evaluation. To enhance the ethical procedures and protocols further, ethical clearance for the evaluation was sought from and granted by the Zanzibar Health Research Institute (ZHRI). Annex 10 provides details of the ethical clearance certificate.

The next sections detail the methodological details, key data sources and associated instruments used to inform the evaluation.

Data Sources

Secondary and primary data sources were used for the evaluation. Secondary data sources included:

- Afya Bora annual reports;
- DHIS2;
- Administrative data from partners (the Zanzibar Blood Bank, Save the Children, UNICEF and UNFPA) and departments in MOHZ (nutrition, and health promotion); and
- Case study reports of promising interventions.
- Key government policy and planning documents and reports.
- UNICEF and UNFPA strategic plans and country strategies.

A list of reference documents used for the evaluation are presented in Annex 3.

3.1.4 Primary qualitative data

Primary data collection was undertaken at national, district, facility and community levels and comprised both qualitative and quantitative data. At national level, interviews were conducted with purposively selected persons from the following institutions based on their participation in and knowledge of the project:

- Implementing partners: UNICEF; UNFPA; and Save the Children;

- Ministry of Health Zanzibar (MoHZ);
- National referral hospital i.e. Mnazi Mmoja Hospital; and
- HRH development/Training institutions: Midwifery schools and Medical and/or Para-Medical Schools (Principal/training coordinator).

For the subnational level data collection, both islands (Pemba and Unguja) were included in the evaluation. Four districts were selected in Unguja and Pemba islands (two in each island). This represented 36 per cent of the 11 districts for the two islands. For inclusivity and diversity, the selection of districts considered a mix of available health facilities supported under the project to cover for renovated PHCU+, non-renovated PHCU+[15], and hospitals including the national referral hospital. The selection also considered a mix of both urban-based and rural-based districts. The two districts selected for data collection in Unguja were Urban West B (Magharibi B) and North A (Kaskazini A), whereas Wete and Mkoani were visited in Pemba. A fifth district, Zanzibar Urban (Mjini) in Unguja, has been added to specifically enable the evaluation team to assess project performance at the national Hospital, Mnazi Mmoja Hospital. There were no district level interviews in Zanzibar Urban except the visit to the central hospital and discussions with national stakeholders.

Seven health facilities were selected for inclusion in the evaluation including:

- From Unguja
    - The national referral Hospital, Mnazi Mmoja Hospital, in Mjini;
    - Nungwi PHCU+ and Kivunge District Hospital in Kaskazini A; and
    - Fuoni Kibondeni in Magharibi B-Unguja.
- From Pemba
    - Junguni PHCU+ and Wete District Hospital both in Wete.; and
    - Kengeja PHCU+ in Mkoani District.

In districts where a PHCU+ and district hospital were selected the intention was to assess the efficacy of the referral pathway and continuum of care.

Community level: From each selected PHCU+ facility, one Shehia[16] within its catchment area that received the community health support (CHVs and CHV supervisors) was selected for the community visit. A combination of purposive sampling, where Save the Children was asked to select high performing and underperforming districts, and random selection from the list of Shehias in the catchment areas of selected facilities was used to identify the Shehias to visit. For the random sampling, simple random sampling was used. Accordingly, four Shehias were selected for community level data collection. A total of two purposively selected and two randomly Shehias were visited in each Island.

Shehas[17], CHVs, and CHV supervisors from all four selected Shehias were interviewed. Two religious leaders from two of the Shehias and two Champions from the other two Shehias were conveniently selected to participate in interviews.

Table 5 provides interviews undertaken for the qualitative primary data collection.

[15] The basic health care unit at the village level is Primary Health Care unit (PHCU). The next level is the Primary Health care Centre (PHCC or PHCU+). This is followed by the District hospital and the central hospital, Mnazi Mmoja referral hospital.

[16] Administrative structure Zanzibar is divided into five administrative regions, three in Unguja and two in Pemba. Each region is subdivided into two districts, which make a total of ten districts for the islands. The lowest government administrative structure at the community level is the Shehia.

[17] The Sheha is a government appointed local community leader in charge with community level administration. .

Table 5: Qualitative primary data collection planned and conducted

Level	Target	Data Collection Method	Planned interviews	Actual interviews – National	Actual Interviews - Unguja	Actual interviews – Pemba
National	UNFPA	Key Informant Interviews, Review of Literature and database information	1	1		
	UNICEF		3	3		
	GAC		1	0		
	[a]Ministry of Health Officials (Maternal health, nutrition, WASH, Transport (for referral), Human Resources, Health promotion Unit (HPU), Supply chain, and HMIS sections)		4	4 (HPU, Nutrition, IRCHP, M&E (HMIS))		
	National Blood Transfusion Service		1	1		
	Health Training Institutions		2	1		
	National NGO Partner (Save the Children)		1	1		
Subnational	[b]NGOs/CBOs Partners (for community activities)	Key Informant Interviews and Review of Literature	2		0	0
	Ministry of Health – District Medical Offices and RCH coordinators		4		2- KIIs (with Assistant Director Preventive services and Health education (DMO); Assistant Director Health Services)	1 KII with co-opted members (Wete district, nutrition)
	District Hospitals and selected PHCU+	KIIs with in-charges	12		4 - Group interviews (with	3 KII with facility heads

Level	Target	Data Collection Method	Planned interviews	Actual interviews – National	Actual Interviews - Unguja	Actual interviews – Pemba
					facility leadership teams)	
		FGDs with RMNCAH providers	4		3 FGDs (Nungwi, Kivunge and Fuoni)	3 FGDs with RMNCAH providers
		Case studies	4			
	Local government					2 KIIs – Planning Officer and Chief Planning Officer in Wete district
Community	Community Health Volunteers	Focus Group Discussions	4		1 FGD with CHVs in Nungwi;	2 FGDs – Kengeja and Junguni PHCU+
	Community Health Volunteers Supervisors	Key Informant Interview	4			2 FGDs – Kengeja and Junguni PHCU
	Community Health Volunteers	Case studies	4			
	Mothers/Caregivers	Focus Group Discussions	4			2 FGDs – Kengeja and Junguni PHCU
	Adolescent girls and young women	Focus Group Discussions	4		1 FGD in Nungwi	2 FGDs – Kengeja and Junguni PHCU
	Adolescent boys and young men	Focus Group Discussions	4		1 FGD with Men in Nungwi	2 FGDs – Kengeja and Junguni PHCU
	Mothers/Caregivers	Case studies	4			
	Shehas/Religious leaders/Champions	Key Informant Interviews	4		1 KII with religious leader in Nungwi	2 FGDs – Kengeja and Junguni PHCU

[a]Interviews were conducted with most critical as availability was a challenge.

[b]*the project only worked with Save the Children as the only NGO in both Islands. So, no additional interviews were conducted apart from Save the Children.

Table 6: FGDs conducted in Unguja and Pemba

Target Group	Planned Discussions	Actual Discussions – Unguja	Actual Discussions - Pemba
*NGOs/CBOs Partners (for community activities)	2	0	0
District Hospitals and selected PHCU+ (RMNCAH service providers)	4	3 FGDs (Nungwi, Kivunge and Fuoni)	3 FGDs with RMNCAH providers
Community Health Volunteers	4	1 FGD with CHVs in Nungwi;	2 FGDs – Kengeja and Junguni PHCU+
Community Health Volunteers Supervisors	4		2 FGDs – Kengeja and Junguni PHCU
Mothers/Caregivers	4		2 FGDs – Kengeja and Junguni PHCU
Adolescent girls and young women	4	1 FGD in Nungwi	2 FGDs – Kengeja and Junguni PHCU
Adolescent boys and young men	4	1 FGD with Men in Nungwi	2 FGDs – Kengeja and Junguni PHCU
Shehas/Religious leaders/Champions	4	1 KII with religious leader in Nungwi	2 FGDs – Kengeja and Junguni PHCU

3.1.5 Quantitative data collection tool

The primary quantitative data collection comprised five tools administered during interviews with stakeholders and at the facility level as follows:

a) **QTT1 Health Information Systems Data Extraction Form**: was used to guide the data required from the DHIS2.
b) **QTT2 MOHZ Reports Summary Form**: collected information on activity reporting from various MOHZ departments.
c) **QTT3 Project Reports Summary Form**: was used to collect information on specific indicators whose data resided in partners and beneficiaries of support.
d) **QTT4 Health Facility Assessment Tool**: this tool collected information RMNCAH services available at the facility, availability and type of youth friendly services, availability and functionality of equipment and supplies, referral system in use and its functionality, infrastructure, and availability and use of policies and guidelines in the facilities.
e) **QTT5 Afya Bora Supported Policies**: collected information on available policies at health facilities.

The Health Facility Assessment tool was administered in all seven health facilities visited for the evaluation.

Data Collection

The assessment was tailored in such a way that maximum but focused amount of data was collected to answer evaluation questions. Data collection involved the consultants and qualified and experienced research assistants under direct support and supervision of technical consultants.

3.1.6 Quantitative data

Quantitative data came from existing secondary sources particularly HMIS, facility services records, and project performance reports. Data collectors used data abstraction forms to capture indicators of

interest for this evaluation. The abstraction forms captured data for key variables for project performance. This was aggregate data hence the data collectors were not able to see any individual identifiers for service utilization data. For cross-sectional services coverage, the evaluation considered data from the last complete quarter of the project's performance period (July-September 2019). For outcome/impact indicators, the evaluation extracted data for the last complete quarters of the year 2019 (January to September 2019). Where appropriate and available, comparative data for the similar period of the year before the intervention (January-September 2015) was extracted for performance analysis.

3.1.7 Qualitative data

The technical consultants, assisted by research assistants, conducted qualitative data collection. These assistants underwent training on the tools, before fieldwork, to ensure they were adept at the evaluation's requirements. Tools for qualitative interviews at national and sub-national levels were in English and Kiswahili, with flexibility for interviewees to discuss in the language of their choice. Tools for FGDs and KIIs at facility and community levels were in Kiswahili. Translation from Swahili into English was done during transcription into Microsoft Excel and kept securely until analysis was complete. Translation and transcription were verified by two study staff.

Data Management and Analysis

Data was analysed to show contribution of the project observed outcomes by first determining achievement of targets and second determining the causal chain.

Quantitative data: secondary data analysis included before and after comparisons and trend analysis to determine points of divergence in trends and how the project influenced that divergence.

Qualitative data: all qualitative transcripts were transcribed in Microsoft Excel according to respondents, themes and questions to prepare for analysis. Atlas ti, a qualitative data analysis software, was then used to identify emerging themes from the data and the supporting quotations.

All primary data was anonymised to ensure confidentiality. Access to this data remained with the technical consultants. Upon completion of the evaluation all data was handed over to UNICEF as part of the MDS' contractual obligation.

Limitations of the Evaluation

1. **Unavailability of some stakeholders**: some stakeholders who had been scheduled for interview meetings became unavailable during the field visits by the evaluation consultants. However, the impact of this was limited as the majority of stakeholders were met and data saturation was met.
2. **Limited visibility of Afya Bora at subnational level**: Afya Bora as a project was not visible at district and facility levels. It would take probing to ensure stakeholders were talking about interventions from Afya Bora. This had the risk of getting information on performance of other projects not Afya Bora. The impact of this was limited by ensuring we referred to interventions of Afya Bora rather than the project name in cases where the conflation was great.
3. **Some indicators in the project's results framework had no baseline or their data was not collected by the Zanzibar DHIS**. These indicators were excluded from the analysis of project performance. The full scope of the project's achievement could therefore not be ascertained. However, the proportion was of these indicators was less than 20 per cent and therefore did not have a significant influence on the evaluation's findings as agreed in the Inception Report.

4 Findings

This section presents findings of the evaluation.

Relevance

To what extent are the project design, results and implementation strategies relevant to the national and local context, strategies, policies and programmes?

Finding: The Afya Bora Project was well aligned to the relevant national priorities, policies, and strategies; UNICEF global priorities; and Government of Canada global priorities.

4.1.1 Alignment to national priorities (Revolutionary Government of Zanzibar policies and strategies)

The project was well aligned with the priorities of a number of national reference documents. The Zanzibar Health Sector Strategic Plan III 2013/14-2018/19 (ZHSSP III), identified and incorporated initiatives to broaden the stipulated goals and priority areas. These initiatives included, health system strengthening (HSS), including HRH, as a key element in promoting quality of delivered health care services. The project aligned with the ZHSSP III in terms of the overlap of targeted priority areas (RMNCAH) and the implementation approach that also incorporates HSS through HRH, infrastructure development, service delivery and provision of essential equipment. In addition, implementation of the activities for RMNCAH component were aligned with the approach for RMNCAH as stipulated in the ZHSSP III. The ZHSSP III identified 11 strategies for implementing the RMNCAH component. However, there are sub-elements of the strategies such as screening for cervical cancer, mitigating sexual and gender-based violence and male reproductive health that are not reflected in the project. Additional areas include increasing SRH and adolescent health services.

The goal of the project was aligned to the Road Map Strategic Plan to Accelerate the Reduction of Maternal, New-born and Child Deaths and Adolescent Health (2015-2018). This document states the government's commitment and priority of the health and well – being of women and children in Zanzibar.

The goal of the Strategy for Growth and Reduction of Poverty III, 2016-2020 (MKUZA III) focuses on addressing growth and human development. The priority sector for wellbeing and social services, consists of goals that focus on reducing infant and child mortality through improving access to and utilization of quality newborn and child health services; and improving maternal and reproductive health outcomes. The cluster strategies for the later include:[18] Although the project was well aligned with the priorities of MKUZA III, the specific activities under the intervention packages differ.

United Nations Development Assistance Plan (UNDAP) UNDAP II consists of 23 UN agencies working together to achieve 12 development and humanitarian outcomes that can be categorized into four themes. The project was aligned with the Healthy Nation theme, addressing three of the four outcomes that included:[19] UNDAP II incorporates the UN programing principles including enabling provision of quality services for the poorest and most vulnerable; women's empowerment; and

[18] increasing the number and improving the quality of skilled birth attendants; expanding delivery services at the PHC level and creating a conducive environment to attract facility-based deliveries, strengthening EmOC services and creating demand for quality services; and improving the availability of Family Planning information and services for men and women.

[19] Increased coverage of equitable, quality and effective nutrition services among women and children under five; Improved access to equitable, acceptable and affordable quality health services; and Vulnerable groups have increased access to safe and affordable water supply sanitation and hygiene.

capacity development which are reflected in the activity outputs for the project under review. Other UN programming principles potentially applicable to this project, such as results-based management are at least not explicitly reflected in the project under review.

Afya Bora was strongly aligned to the following priorities in the UNICEF's United Republic of Tanzania country programme (2015-2020) priorities: strategic placement of 24-hour emergency obstetric and newborn care facilities; strengthening health systems at the district level; and communication for development (C4D) efforts to promote healthy family care practices for children and mothers. In line with the country programme's emphasis on building sustainable health systems, Afya Bora had a strong focus on review and establishment of policies, and guidelines.

With regards UNFPA's country programme 2016-2022, the project was strongly aligned to objective 1 of Increased national and subnational government capacity to deliver integrated sexual and reproductive health services to women and men. However, focus on adolescents and young people, a priority target group for the country programme, did not receive sufficient attention in the design.

4.1.2 Alignment to UNICEF global priorities including the five areas for RMNCAH and UNFPA global priorities

The project was aligned to the UNICEF's Global Strategy for Health (2016-2030) Priority areas and the goals of: (i) ending preventable maternal, new-born and child deaths; and (ii) promoting the health and development of all children including health, HIV/AIDS, WASH, Nutrition and social inclusion. It also implemented Every Newborn Action Plan (ENAP) evidence-based interventions for newborn as were led by UNICEF and WHO experts. This project advanced these goals through implementing activities under health, WASH and nutrition priorities, but it`s focus did not include HIV/AIDS and social inclusion. The assumption is that HIV/AIDS could have been addressed through other initiatives focusing on eMTCT as per the UNICEF's country programme. Afya Bora was aligned to the Global strategy for Women's Children's and Adolescents' Health 2016-2030.

UNFPA's Strategic Plan (2018-2021) commits to prioritizing: ending unmet needs for family planning; ending preventable maternal deaths; gender-based violence and harmful practices, with emphasis on women and youths as the agents for sustainable development. Consistent with other strategies and initiatives, the model emphasizes five focus areas. The project focused on two of the areas, namely:[20] In addition, UNFPA's strategy emphasizes protection of youth`s rights to SRH through advocacy and also focuses on empowerment of young people to play a vital role in their own development and in their communities, helping them to acquire life skills and promoting positive civic action. Activities for the project under review include promotional SRH messages for youths, but it was not clear to what extent this component of protection and empowerment was incorporated, as youth interviewed could not provide details of support provided by the project to them. Further discussions with UNFPA and UNICEF revealed that while adolescents and young people were a priority target group in the design, they were left behind in implementation through the CHV programme and support to health facilities. The UNFPA strategy also emphasizes integration of SRH services with HIV/AIDS programming, which is not a part of the approach for the project under review.

[20] SRH and rights with activities promoting access to SRH information and services including for young people, strengthening health system through infrastructure and HRH for RMNCAH including EmONC; and adolescent and youth focus with activities such as promoting youth-friendly SRH services.

4.1.3 Alignment to Government of Canada global priorities

Canada's Department of Foreign Affairs, Trade and Development (DFATD) priority thematic areas are:[21] This project under review was aligned with the priority area of securing the future of children and youths and it`s deliberate attention to the marginalized is consistent with the DFATD`s mandate of accounting for the poor / disadvantaged. Through the Muskoka Summit initiative and through the Global Affairs Canada (GAC), the government of Canada has committed to making RMNCAH a priority, funding cost-effective interventions towards women's and children's health with focus on improving the services and care needed to ensure healthy pregnancies and safe delivery. This project, therefore, was well aligned with the priorities of the Canadian government / Muskoka Summit, through implementation of activities such as, setting up 24 hour-EmONC services, RMNCAH-related training and expansion of HRH availability, and promoting breastfeeding. The Muskoka initiative emphasizes on meeting the nutritional needs of pregnant women, mothers, newborns and young children. However, activities towards promoting nutrition included awareness messages but emphasis on addressing nutritional needs for pregnant women may be subject to further review (i.e. it is not clear whether there were any additional activities beyond the promotional messages). The project did not focus on HIV/AIDS and malaria, which is one of the key components of the Muskoka initiative.

4.1.4 Flexibility of design to accommodate emerging issues

Finding: The project demonstrated flexibility in project implementation supporting decentralisation and inclusion of missing elements during project implementation.

During the third year of Afya Bora implementation, decentralisation came to effect, which led to district level health system management transferred from central to local government/councils. The project was able to shift capacity building of DHMTs to the newly formed CHMTs. However, this was without challenges as noted in Section 0 on Effectiveness.

Family planning and male involvement were not included in the design of Afya Bora despite their influence on improved RMNCAH. In the second year of the project the importance of addressing these areas became more apparent and led to their inclusion in the CHV programme from the third year. A combination of savings from budget lines and own resources from partners were used ensure these critical components were a central part of the CHV programme. Inclusion of SRHR interventions were beyond the CHV programme- the interventions included are male involvement looking at two key behavioural outcomes; male as decision makers at family level, and men supporting their partners to access SRH information and services. The other group that was engaged is religious leaders to demystify myths and misconceptions around Islam and FP.

> *"SRH was not a strong component but as we went along we brought the male involvement to the fore. We have included 13 male groups (cooperatives, and some male dominated groups e.g. religious leaders). Looking at men as partners for SRHR and as influencers in their own rights as heads of households and decision makers…"* **Implementing partner**

> *"We realised SRH was missing in the project implementation. Family planning was a big gap…We used our own resources to address the gaps."* **Implementing partner**

The project had no plan for strengthening HRH information systems. However, in building capacity of HRH there were major challenges on determining where the gaps in HRH were to guide investment decisions. The project undertook a study to determine systems available to provide MOHZ with evidence to assist in human resources placement. The study found no functional HRH systems in the MOHZ to provide evidence on human resources. Using the study, Afya Bora, through UNFPA, was able

[21] increasing food security, securing the future of children and youth, stimulating sustainable economic growth, advancing democracy, and ensuring security and stability.

to influence the establishment of the HRH information system in the MOHZ and in the process enhancing HRH management.

A mentorship programme was introduced in the project after a realisation that assistant medical officers who were trained under the task shifting for CEmONC were not undertaking caesarean sections due to limited confidence. Two roving mentors were recruited to support new trained staff. This approach immediately led to an increase in caesarean sections in targeted district hospitals[22].

Additionally, the project was supposed to end and close after three years of implementation, however, due to delays in starting implementation of some activities such as CHV programme and given its envisaged importance, a one year no cost extension was flexibly granted by the Government of Canada, the project funder.

4.1.5 Validity of assumptions for the Theory of Change

As presented in section 0, the main assumptions of the Afya Bora Theory of Change were:

- Demonstration and implementation of best practices will lead to eventual government ownership.
- The right caliber of health professionals is trained and 1) are of adequate numbers to deliver quality service; 2) have sufficient institutional support to facilitate full utilisation of new skills and knowledge gained, and 3) will be and remain in post during the implementation period.
- CHVs will remain highly motivated and in post and deliver the full package of services – RMNCAH, WASH, and Nutrition.
- RMNCAH clients can meet the cost of care.

Finding: In general, the assumptions held.

By designing with and implementing through the MOHZ structures, the project was able to build traction within the MOHZ. This ownership has been cemented through strategies developed through the project[23]. Community health strengthening, through the CHV initiative, provides a clear example of this ownership, which has led to scaling up of the programme through the community health strategy. HRH information system developed as part of the project is enabling the MOHZ to allocate better human resources in facilities. MPDSR system has enabled the ministry to capture maternal and perinatal deaths more efficiently and better understand the causes and contributing factors to these deaths.

In terms of institutional support for utilisation of skills and knowledge, the findings are mixed, and this assumption may have transformed into a risk for the project. Transfers and task shifting all had an impact on utilisation of knowledge and skills. At Mnazi Mmoja for example, seven midwives were trained but only three remained at the hospital and two were working in maternity with others having relocated. In Kivunge PHCU+, the trained staff stayed for two months and proceeded to relocate to a facility where there were no deliveries until the facility demanded the trained staff to return. General staff shortages, as discussed under effectiveness, have had a negative impact on the improvement and continued delivery of improved RMNCAH services in targeted facilities.

[22] See UNICEF and UNFPA (2018) MPTF Office Generic Annual Programme Narrative Progress Report Reporting Period: 1 April 2017 – 30 April 2018 Report prepared for the Canadian Government

[23] Zanzibar Multisectoral Nutrition Action Plan (ZMNAP) 2019/20 – 2023/24; Zanzibar Reproductive, Maternal, Newborn, Child and Adolescent Health Strategic Plan (2019 – 2023)

Over 90 per cent of CHVs remained in post over the duration of the project due to: 1) allowances provided by the project; and 2) motivation of CHVs from their increased stature in the community and results achieved with their behaviour change communication. This allowed for continued and uninterrupted exposure to messaging RMNCAH, WASH, and Nutrition.

Health care services are free in Zanzibar however; clients have to incur the costs of travelling to the facility to seek care. While in all PHCUs visited for the evaluation respondents did not express challenges related to cost of accessing facilities challenges arose on referral to second level facilities which, if the facility is far from the district centre, potential clients have to pay a higher transport cost. Challenges still remained for those on small islands, especially in Pemba in Wete district (e.g. Fundo), who have to hire boats to cross to the nearest facility. For this population, access to quality RMNCAH services is still problematic.

Effectiveness

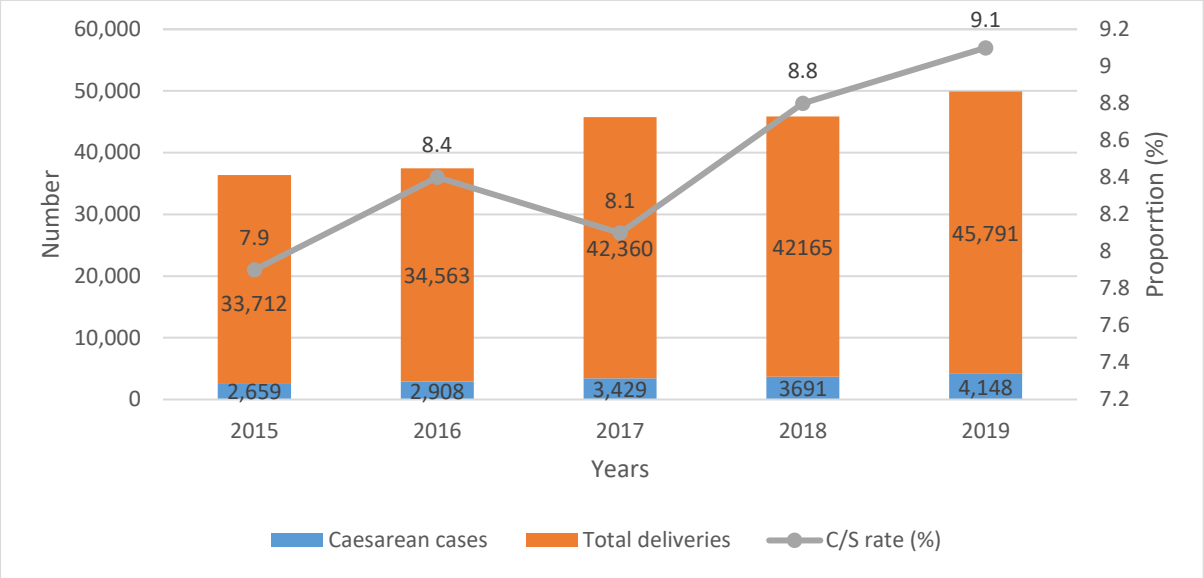
4.1.6 To what extent have the project's objectives and intended results been achieved?

Finding: The project made significant achievements meeting or exceeding at least 50 per cent of its targets. Annex 4 presents analysis of project performance against set targets. The evaluation was able to collect data from its data sources for 22 targets representing 52.4 per cent of total of 42 targets include in the indicator based performance matrix. Out of the total assessed targets, the project was able to meet 18 out of 22 (81.8 per cent) and only 4 targets (18.2 per cent) were not met. Performance on some targets that had no data for verification during this evaluation was presented in the final project report and it is also included in Annex 4.

Over the period of project implementation, there was a demonstrated improvement in performance of health system practices and coverage of services related to RMNCAH in Zanzibar. Some key observed results include:

- Maternal and perinatal deaths reviews: All health facilities in Zanzibar that are currently conducting deliveries are reported to practice maternal and perinatal death reviews. For the 2-year period (2018-2019) with proper documentation of this practice, there is an observed 17.3 percentage points increase in proportion of maternal deaths being audited at facility level, from 71.4 per cent in 2018 to 88.7 per cent in 2019 (Source: HMIS data). Data on number of perinatal deaths audited was not being collected until later in 2019, hence there is no information for comparison.
- Proportion of health facilities reporting no stock out of RMNCAH supplies throughout a year was maintained above 90 per cent (since the baseline was already very high at 94 per cent).
- Caesarian section rate among all facility deliveries increased from 7.9 per cent in 2015 to 9.1 per cent in 2019 as per Figure 5. The total number of facility deliveries also increased from 33,712 in 2015 to 47,989 in 2019 (source: HMIS data).

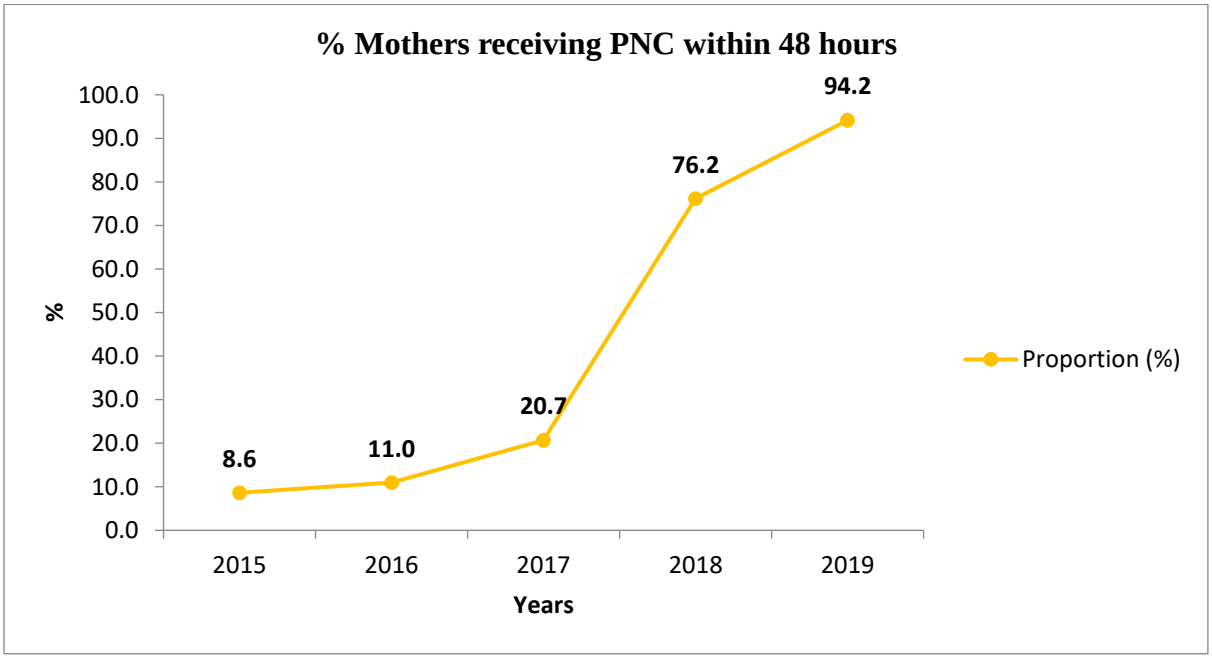
Figure 5: Trend of facility deliveries and Caesarean section in Zanzibar by years from 2015 to 2019



Source: HMIS data

- Actual number and proportion of mothers receiving postnatal care within 48 hours after child birth increased from 2,909 mothers (8.6 per cent of all deliveries) in 2015 to 43,117 mothers (94.2 per cent of all deliveries) in 2019, with initial gradual increase between 2015 and 2017 and a hug leap in 2017 as demonstrated in Figure 6. (source: HMIS data).

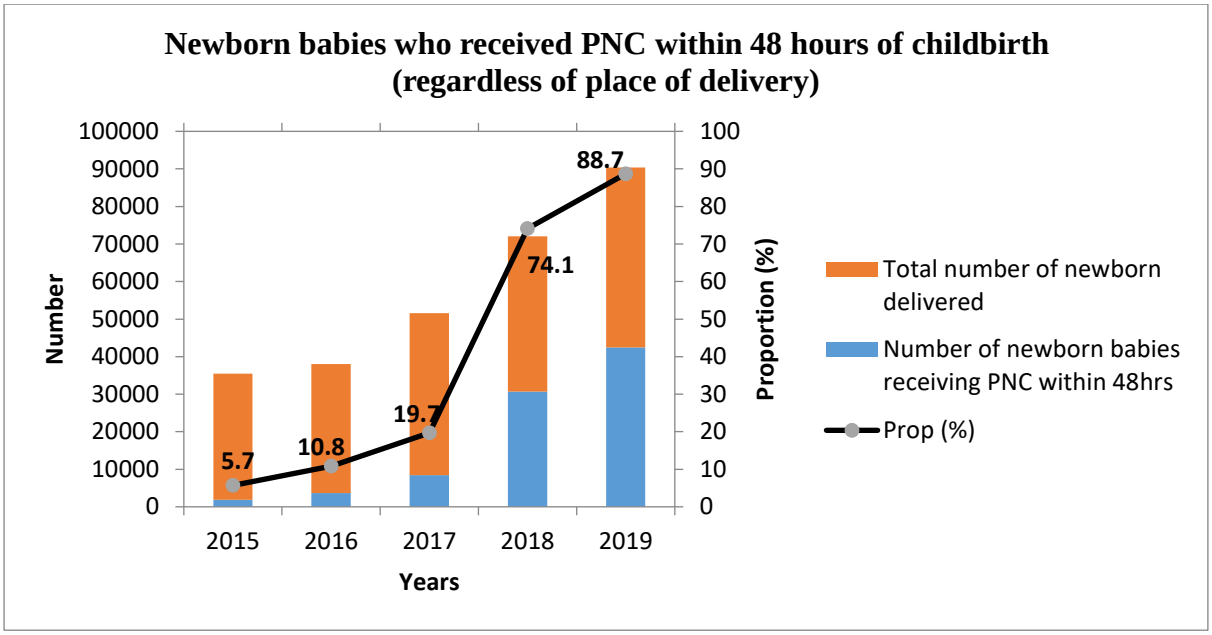
Figure 6: Proportion of mothers receiving PNC within 48 hours in Zanzibar by Years



Source: HMIS data

- Actual number and proportion of newborns receiving postnatal care within 48 hours after birth increased from 1,899 newborns (5.7 per cent of all deliveries) in 2015 to 42,496 newborns (88.7 per cent of all livebirths) in 2019, with observed gradual increase over years as demonstrated in Figure 7. (source: HMIS data).

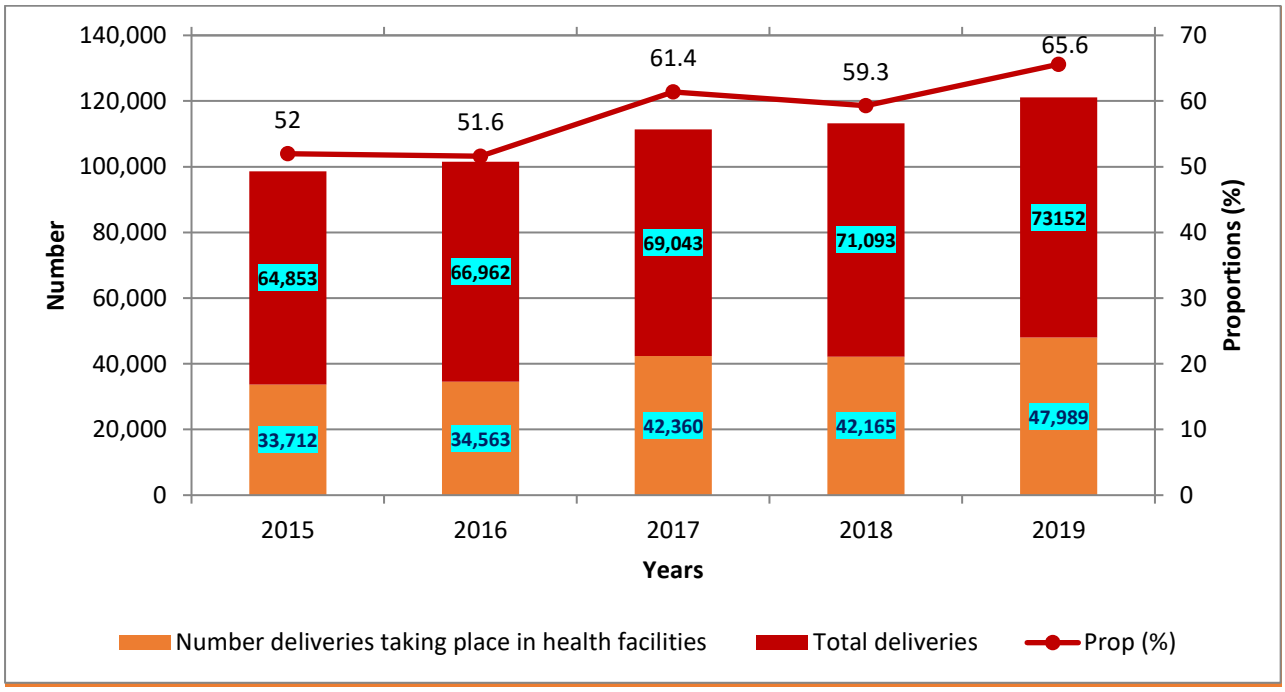
Figure 7: Proportion of newborns receiving PNC within 48 hours in Zanzibar by Years



Source: HMIS data

- Number and proportion of deliveries taking place in health facilities increased from 33,712 (52 per cent) in 2015 to 47,989 (65.6 per cent) in the year 2019 as per Figure 8. (source: HMIS data).

Figure 8: Number and proportion of Deliveries taking place in health facilities from 2015 to 2019



Source: HMIS data

Project stakeholders at various levels testify to the positive change realized in health of women and children from project sites over life of the project.

> *"There is observed reduction in maternal, newborn and child deaths. There have been no maternal deaths at this facility for a long time (since the new building was launched two years ago). In 2019, there has been only one case of fresh still birth. Most still births are macerated".* (Facility management team, Magharibi B)

> *"Most mothers were delivering at home (before the project started). There was a delay in seeking care. This led to many deaths, of the mother and/or the baby (newborn). With the project (Afya Bora), mothers and communities are seeking care timely whenever there is a need….".* (FGD of Men with children of ≤5yrs old children, North A)

> *"(We now see) early antenatal booking. Before pregnant women would book at 8 months but now you see them come even before 12 weeks"* (Hospital management team, North A)

> *"There are changes (in communities). (for instance) There is a significant reduction of malnutrition problem among children, safer births for pregnant women, and reduction of children illness".* (Opinion leader, North A)

4.1.7 What are the factors that facilitated or inhibited the achievement of the project's objectives and outcomes?

Through interviews and engagement with various stakeholders during evaluation, there were a number of factors identified to either facilitate or hinder the achievement of project's results. The table below provides a summary of factors in various aspects of the project.

Table 7: Barriers and Facilitators for project achievement

Aspect/Area	Facilitators	Barriers
Design	- A programme designed closely linked to the multi-dimensional drivers of poor MNCH outcomes - Inclusion of CHVs programme, with involvement of both male and female CHVs and supervisors. Women were the majority. - Holistic program focusing on both supply and demand sides - Strengthening of health system components including infrastructure, equipment and supplies, and HRH.	- Inadequate involvement of stakeholders at local/sub-national level in project design - limited focus on family planning. - There were limited gender considerations (detailed under the gender section)
Implementation	- Recruitment and deployment of CHVs in their respective communities	- CHV program was known to fewer facility-based staff. This limited their ability to support CHVs if the CHV supervisor was absent

Aspect/Area	Facilitators	Barriers
	- Male involvement has facilitated utilization of Family Planning (FP) services - Involvement of various stakeholders (Professional groups i.e. Nurses association, community and religious leaders, MoHZ technical departments, etc. - Leveraging Government resources such as vehicles, health care workers and buildings to support project activities	- Despite that the program intended to engage both men and women volunteers, men were less interested in the roles as either CHVs or CHV Supervisors. This could be due to men's behaviour not to take up lower paying jobs. - Shortage of human resources: Some HFs were renovated and/or equipped but they are yet to start providing delivery services (Tumbatu PHCU+ and Mtangani PHCU+ - No funds to support YFSs peer educators after training them. There was little integration of adolescent and/or youth-friendly services in CHVs routine work.
Monitoring and Evaluation	- Working through the routine HMIS system - Establishment of Quality Improvement (QI) system, including QI tools - Regular project performance review meetings at both national and sub-national levels	• Inadequate funds for post training follow up and supervision of youth services initiatives • Poor documentation at health facilities and inaccessibility of facility level data to NGO partner • Non-functional national health systems for human resource • Limited systematic communication among all stakeholders of agreed action points could have been improved as well as better use of timely data for timely decision making.
Management and Oversight	- Good collaboration and oversight from the UN agencies and the MOHZ (through the project coordination committee) -Involvement of technical departments at the Ministry of Health in planning and implementation - Having supervisors of CHVs at both community and facility	• Limited involvement of local Government leaders in decision making on project priorities

4.1.8 *Which project activities had more significance to contribute to increased demand, coverage and uptake of quality emergency obstetric care, new-born and child health services, including high impact nutrition interventions?*

Finding: The successful deployment of community health volunteers led to a significant increase in demand for MNCH services in Zanzibar.

In collaboration with the Revolutionary Government of Zanzibar (RGOZ) through the Ministry of Health, and the local government (the District Heath Management Teams), Afya Bora project established a network of 1,760 Community Health Volunteers (CHVs) and 88 community-based Supervisors covering 963 villages and 332 Shehias in 10 districts (out of the total 11) for both Unguja and Pemba islands. Women were the majority among both CHVs (78 per cent) and CHV supervisors (61 per cent). Despite that both sexes were encouraged to join the program, the roles were less appealing to male community members likely due to its volunteering nature. At the time of assessment, the program had remained with 1,340 CHVs (1,007 women and 333 men) and 68 supervisors (44 women and 24 men), which presents an attrition rate of 23.9 per cent and 22.7 per cent among CHVs and supervisors, respectively. At baseline (2015/2016), only 140 Shehias had at least one CHV out of the total 346 Shehias (40 per cent). With CHVs training scale up under Afya Bora from 2016/17 and 2017/18, the coverage of CHVs network has increased to 332 Shehias out of the current total 389 Shehias in Zanzibar (85 per cent). The urban district in Unguja and its Shehias do not have CHVs program by project design. All 332 Shehias with CHVs are regularly reporting on CHVs activities, which reflects on active engagement of CHVs in community sensitization, mobilization and education activities around RMNCAH, WASH and Nutrition issues. Community outreach by CHVs was immense. Over three years the CHV component was able to reach the following:

- 152,194 children under five (85 per cent of target,179,046)
- 42,467 pregnant women (93 per cent of target, 45,645) incl. 16 HIV+ women identified
- 108,238 caregivers (93.8 per cent of target, 115,402) (approx. 25 per cent men)
- 64,632 adolescent girls and boys (154 per cent of target, 42,000)
- 26,717 influential leaders (156.4 per cent of target, 17,080)[24]

All stakeholders interviewed during the evaluation provided a very positive perspective of the CHV program. Health care providers and health managers at various levels acknowledged the contribution of the community program and CHVs in raising awareness on Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) and Nutrition and WASH services among community members. Stakeholders in both Unguja and Pemba attributed the improvement in utilization of RMNCAH services to a great contribution by the presence of CHVs in the communities.

> *"…… demand for antenatal and postnatal services has increased more than before (the project). The growth Monitoring and immunization (coverage) has improved as the number of the mothers and children coming for immunization are increasing day after day. Facility based deliveries have (also) increased, since CHVs are working effectively.* (Nurse in charge, Wete)

> *"The CHVs program has improved community engagement. More clients are now coming (to the health facility) and we see: (an increased) demand for antenatal and post-natal services, with more early ANC booking, more ANC visits and more PNC visits; increased immunization coverage with CHVs conducting defaulter tracing; (and) a positive trend in facility deliveries with almost 90 per cent of women delivering at the facility. We receive more referrals accompanied by CHVs and TBAs".* (Nurse in charge, Nungwi)

[24] Powerpoint Presentation from Save the Children.

"There is improved health seeking for children with malnutrition. (Communities are) reaching out to CHVs and going to the health facility (in time). ……CHVs are being trusted. (For instance) pregnant women get information from CHVs and deliver in health facilities. (Besides), women using family planning methods trust CHVs even when they are using FP in confidence. (Local Government Staff, Magharibi B)

"…. with CHVs support, most malnutrition cases are brought to the hospital (in time). But as we proceed, we see a decline in cases since the community is now more sensitized on proper nutrition (hence preventing malnutrition)". (Facility management team, Magharibi B)

Since the introduction of CHVs in Shehias under Afya Bora, most interviewed stakeholders believe that communities are healthier and there are improved outcomes related to RMNCAH and Nutrition. As a result of community awareness and adoption of healthier preventive practices as well as timely health seeking behaviour, some examples of reported results at both community and facility levels include: reduced cases of acute malnutrition and stunting; less maternal and perinatal deaths; better planning of pregnancies; etc.

"…… There are (recently) fewer cases of malnutrition following nutrition education (by CHVs) (Health facility in-charge, Nungwi)

"Most mothers were delivering at home (before the project started). There was a delay in seeking care. This led to many deaths, of the mother and/or the baby (newborn). With the project (Afya Bora), mothers and communities are seeking care timely whenever there is a need. This has brought more "safety" in the community. Those people (CHVs) are moving around in the community giving education". (A participant of FGD of Men with under 5yrs old children, Kaskazini A))

*"With the new education (from Afya Bora), people are planning their families better with birth spacing. Hence, children are getting better services (social support and nutrition)". (*A participant of FGD of Men with under 5 years old children, Kaskazini A)

Community health volunteers and their supervisors perceived a self-efficacy regarding their role in the project. They reported being trusted by the community and causing a positive impact in lives of women, children and adolescents engaged in project activities, including positive male involvement in RMNCAH services.

*"We are accepted, famous and trusted. Even at health facilities we are trusted to give health education. (We) improved health status (of the community) including healthy children by reducing stunting. This has reduced the burden for the country……Before the children were closely spaced. But now, they (women) appreciate the benefits of family including resting the body (between pregnancies). …..Men are now more supportive of family planning" (*A participant of FGD for CHVs, Kaskazini A)

"There was a mother who had a sick child. The mother (at first) tried to get traditional treatment as they thought (the child) was bewitched. Diarrhea and vomiting persisted with the child. (We) trained her on proper breastfeeding with clean breasts (and followed her up) for three months. After two months the condition (of the child) had changed (the child was healthy and thriving)". CHVs supervisor, Wete

"There is a woman who delivered six children without going to the hospital. Three died weeks and a month due to complications. I tried to talk to her and the husband. The woman was difficult to understand. The CHV supervisor convinced the husband. When the wife was pregnant the husband convinced the wife to go to hospital [because of what he had been told by the CHV supervisor]. She got severe bleeding during delivery, and was helped by the doctor.

*She came and thanked the supervisor [CHV supervisor] that if you had not helped me, I would be dead." (*A participant of FGD for CHVs, Wete)

Because of their success, CHVs were increasingly recognised as an effective mechanism for mobilising communities for MOHZ programmes. Discussions with staff from the nutrition department of MOHZ highlighted how the CHV were central to their community programmes. The same sentiments were highlighted by CHMTs in Wete and Mkoani districts.

"We always use CHVs to mobilise communities for us when we want to do outreaches on nutrition. We always get high attendances when they are involved." Technical officer, MOHZ.

Finding: Improved infrastructure and availability of equipment supported provision of quality RMNCAH services.

Supports from the Afya Bora project to improve infrastructure and provide equipment for RMNCAH services at project sites were considered to be impactful in ensuring availability and quality of services. Up to 18 health facilities in both Unguja and Pemba received support in infrastructural improvement including:

- improving space for EmONC services (3 sites in Unguja and 3 sites in Pemba);
- construction/renovation of incinerators (2 sites in Pemba);
- construction/renovation of placenta pit (7 sites in Unguja and 3 sites in Pemba); and
- construction of youth-friendly services sites (4 sites in Unguja and 2 sites in Pemba).

Table 8 summarizes the type and number of functional infrastructural improvement supported under Afya Bora.

Table 8: Type of functional infrastructure by facility improved under Afya Bora support

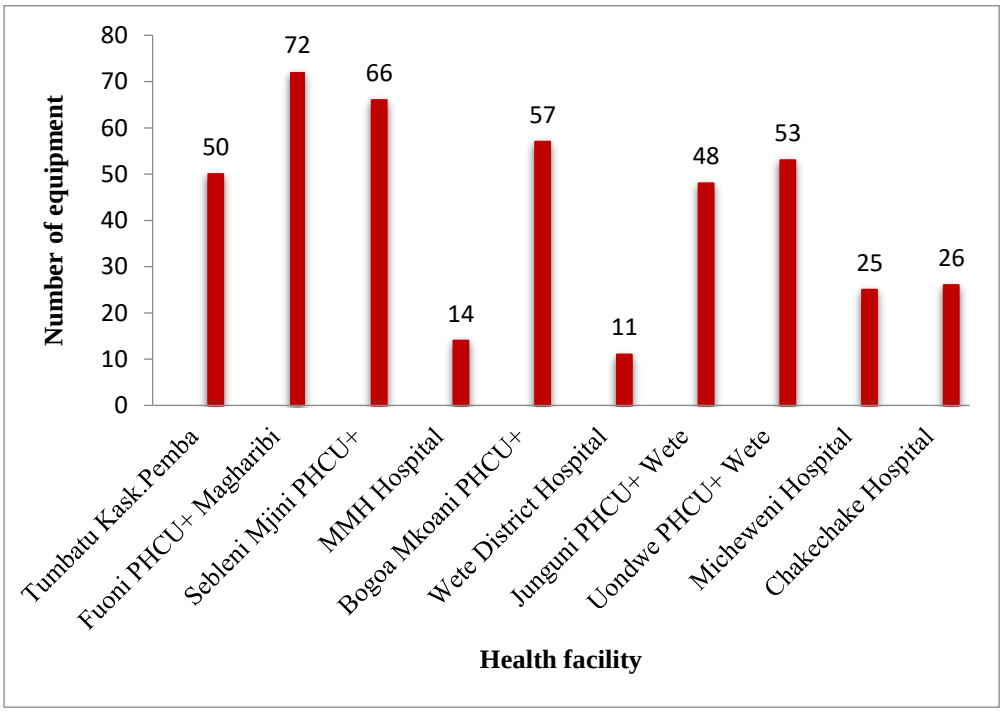
	Infrastructure support	BEmONC/ CEmONC	Youth-Friendly Services	Incinerators	Placenta pit
Pemba	**Junguni PHCU+**	1	NA	NA	1
	Uondwe PHCU+	1	NA	NA	1
	Bogoa PHCU+	1	NA	NA	1
	Bwagamoyo PHCU	NA	1	NA	NA
	Mbuzini PHCU	NA	1	NA	NA
	Micheweni District Hospital	NA	NA	1	NA
	Wete District Hospital	NA	NA	1	NA
Unguja	**Fuoni PHCU+**	1	NA	NA	1
	Tumbatu PHCU+	1	NA	NA	1
	Sebleni PHCU+	1	NA	NA	1
	Mwera PHCU	NA	1	NA	NA
	Suza University	NA	1	NA	NA
	Nungwi PHCU+	NA	1	NA	1

Infrastructure support		BEmONC/ CEmONC	Youth-Friendly Services	Incinerators	Placenta pit
	Bwejuu PHCU	NA	1	NA	NA
	Uzini PHCU+	1	NA	NA	1
	Mfenesini PHC	1	NA	NA	1
	Chake Chake Hospital	1	NA	NA	NA
Total		**9**	**6**	**2**	**9**

Ten health facilities received equipment for RMNCAH services ranging from 11 items to 72 items per facility (Figure 9). Some items distributed to the facilities under Afya Bora support in collaboration with the MOHZ included:

- **Furniture** (Office chairs, office tables, wooden benches, coffee tables, file cabinets, iron tables);
- **electronic equipment** (Laptops, UPS, DVD players, flat TV screens, TV decoder dishes, iron, washing machine, Refrigerator);
- **medical equipment** (Blood machine (Hemocue), Ultrasound machine, Vacuum reusable Omnicup (KIWI), airway devices/Guedel airway, Resuscitators for neonate and adult, Resuscitation table, Incubation machine, electric sterilizer, Suction tubes, forceps, Doppler device for fetal heart, Stethoscope, Hb machine, Glucometer, Pulse oximeter, Anaesthesia machine, Laryngoscope, Baby warmer, Oxygen concentrator set, Midwifery kits renewable, Obstetric surgical kit complete, Delivery sets, Weighing scales, MVA cannulae, Basin kidney, Examination light, Wheelchair, Delivery beds, examination table, Theatre bed, hospital beds, etc); and
- **Automotive tools** (Vehicle, Ambulances, Boat ambulance, Generator).

Figure 9: Number of Distributed RMNCAH Equipments per Health Facility



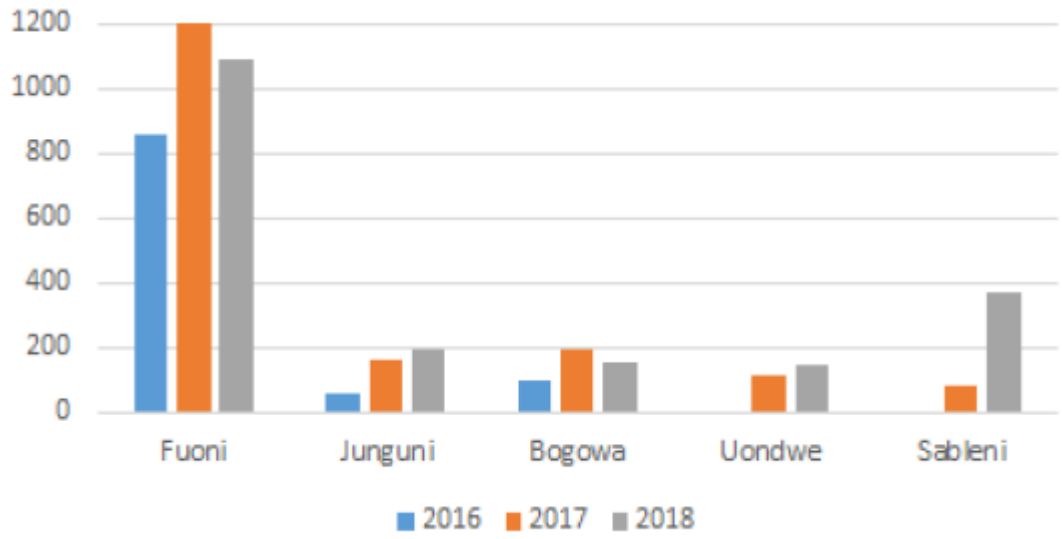
Source: Equipment Distribution report, MoHZ

This kind of support proved to be critical to some communities particularly when new and/or improved services were introduced following project's support on either improved infrastructure and/or making equipment available. For instance, the theatre at Micheweni District Hospital was equipped by the project to be able to start providing C/S services. Fuoni PHCU+ witnessed increased volume of RMNCAH clients following construction of the RCH and maternity building in 2017 and receipt of RMNCAH equipment under the project's support. Construction and/or renovation of incinerators and placenta pit enabled respective health facilities to improve IPC practices and hence the quality of care. Beneficiaries of the support commended the appropriateness and quality of both infrastructure and equipment under Afya Bora.

> *"……(before) The maternity ward was very small (limited space). For instance, there was only one labour room with one delivery bed. The new building by UNFPA (Afya Bora support) for RCH and maternity services was completed and used since 2017. It has 6 rooms: Antenatal care, labour room, postnatal, admission room, RCH/immunization services. ….. The building was completed in reasonable time, equipped and services started. (Health facility management team, West B)*
>
> *"There were no delivery services (labour and delivery) because there was no building and equipment for the maternity services. The coverage and the quality of RNMH services was not good because there were limitations of space and equipment". (Health facility management tea, Pemba)*
>
> *"Renovations and infrastructural improvement considered the needs and standards…" (KIIs, MOHZ)*

As reported in Afya Bora's end of project report, facilities that received support for equipment and infrastructural improvement demonstrated increase in uptake of services, including number of facility deliveries (**Figure 10**). The statements above from health workers at some health facilities substantiates this fact.

Figure 10: Number of deliveries in PHCU+ supported by Afya Bora (2016-2018)



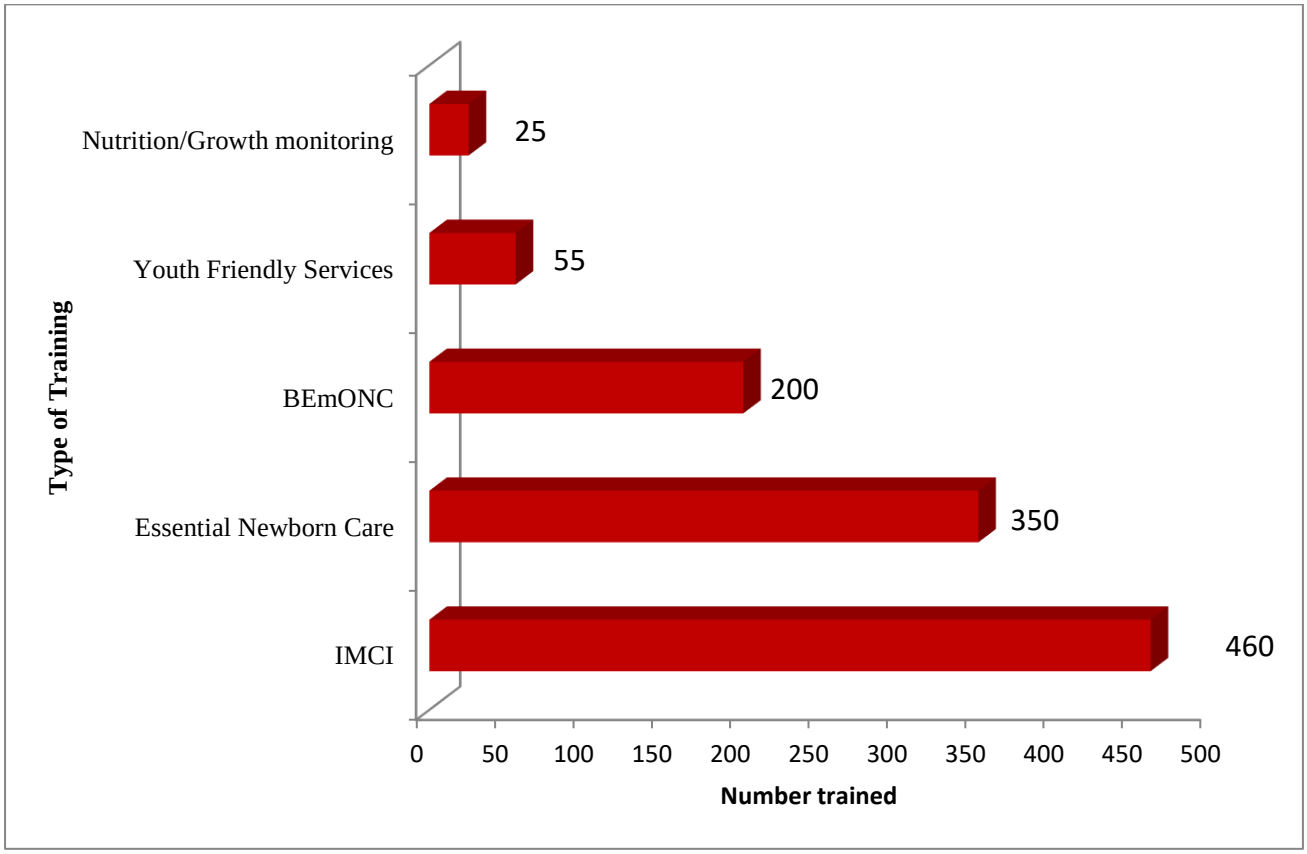
Source: UNICEF& UNFPA (2020): Afya Bora project final report.

Nevertheless, it was found that not all equipment distributed to health facilities were immediately put to use. For instance, there were some equipment at Kivunge district hospital still wrapped in boxes for lack of clear instructions on delivery. It was not clear where the equipments came from, when they were delivered and whether they were from Afya Bora or another partner. At Fuoni PHCU+ they had an infant radiant warmer in the maternity ward, from Afya Bora, that was not in use due to lack of skills to operate it. The health staff reported to have received no orientation on how to use the equipment after it was delivered to the health facility. At the same facility, they had a challenge with use of the ultrasound machine due to lack of skilled personnel. Despite having the machine available at the site, they had to always rely on personnel from the council level who visit the facility once a week for ultrasound services. This makes pregnant women wait in long queues before getting the service. The Wete CHMT also noted this challenge and that ultrasound services are not always available as the district hospital staff may at times not have transport. On probing, there seemed to be no attempt of training a local staff to operate the equipment.

Finding: Training of Health Care Workers in various technical areas improved their competencies and confidence in providing quality RMNCAH and Nutrition services.

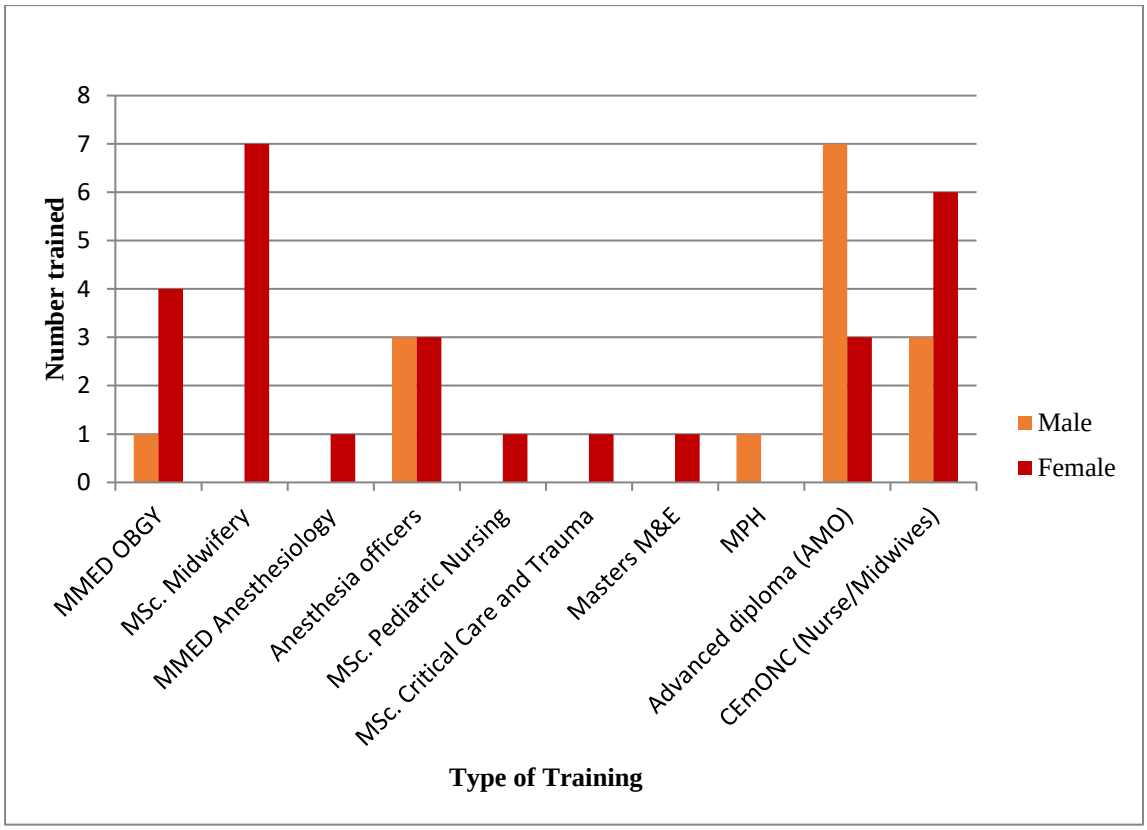
Afya Bora project provided short term, medium term and long term trainings to HCWs at various levels of health care to address gaps in knowledge and skills that would affect the quality of care. The project trained over a thousand health care workers with short-term, medium-term and long-term trainings. Figure 11 and Figure 12 provide detailed information on HCWs trained by type of training. Sources for short-term training data did not consistently disaggregate by sex hence presented only as aggregate numbers.

Figure 11: Number of HCWs who received Short term trainings (less than 3 months) by type of training



Source: Training reports, MoHZ

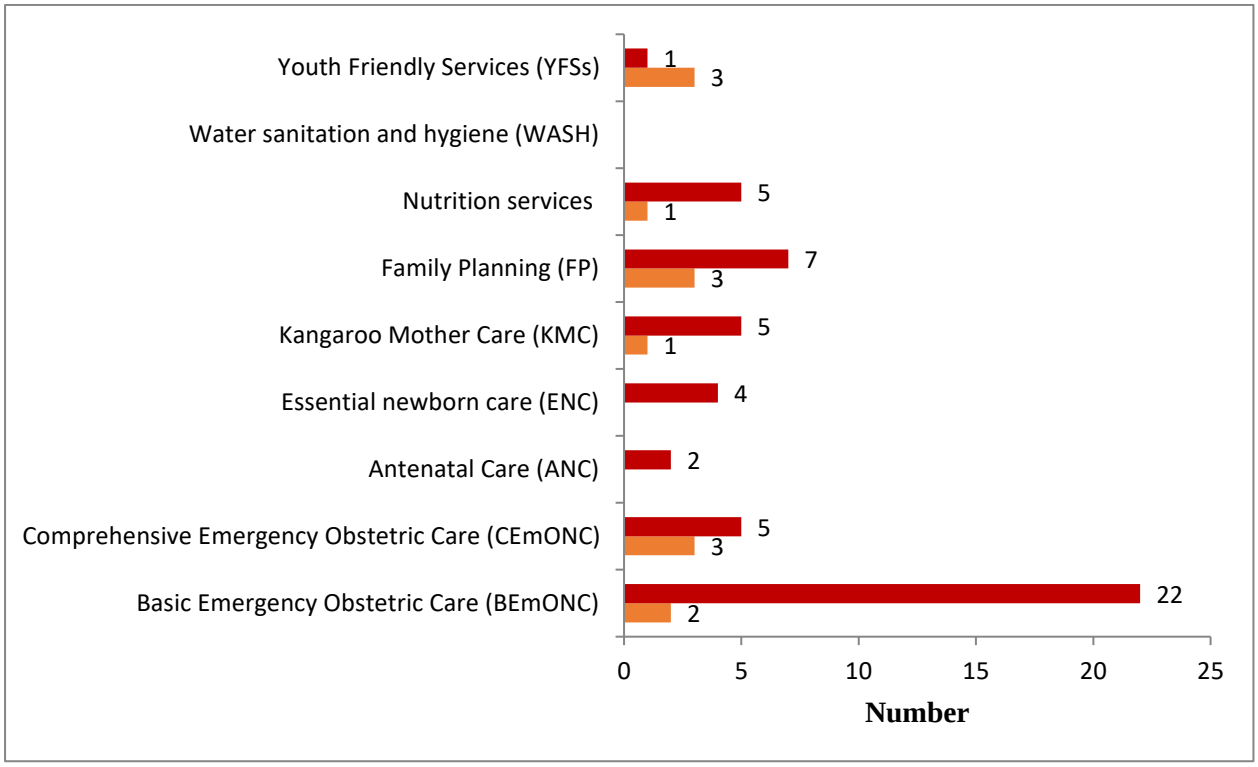
Figure 12: Number of HCWs who received Medium and Long term trainings by Sex (Total number of trained HCWs =42)



Source: Training reports, MoHZ

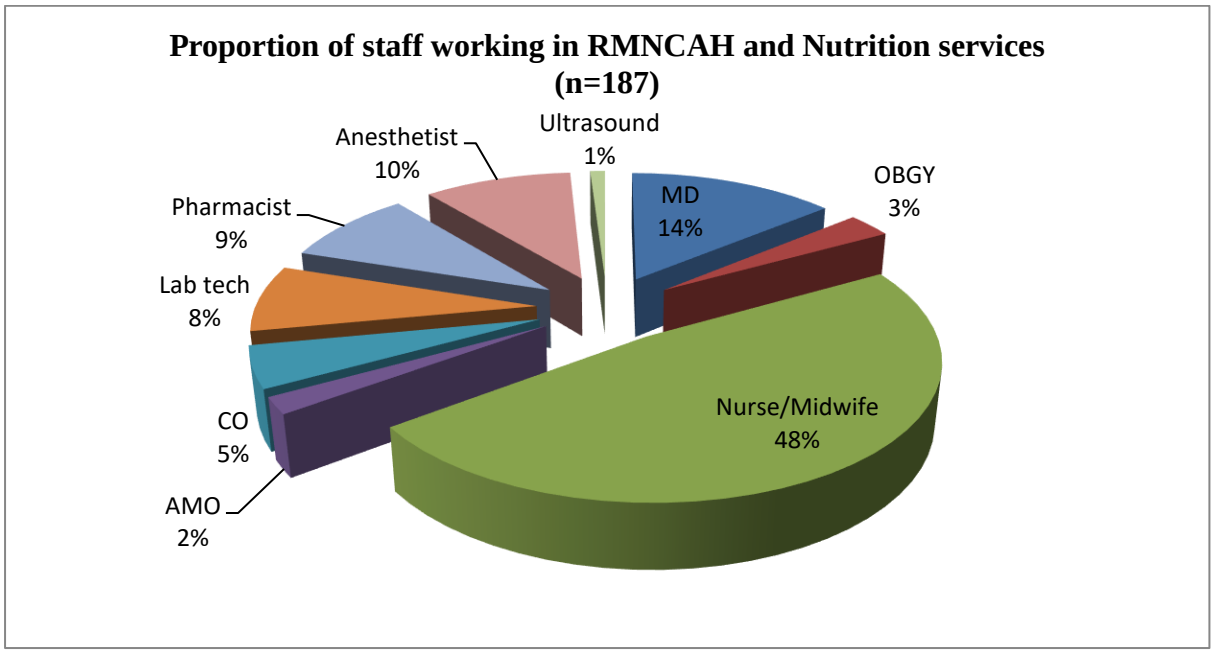
Presence of trained HCWs under Afya Bora was verified at health facilities that were sampled into the study. A total of 7 health facilities were visited in both Unguja and Pemba namely: Nungwi PHCU+, Fuoni PHCU+, Kivunge Hospital, and Mnazi Mmoja Hospital in Unguja; and Junguni PHCU+, Kengeja PHCU+ and Wete District Hospital in Pemba. A total of 64 Health care workers were reported to be trained by the project on various technical areas of RMNCAH and Nutrition, with a majority (32) being trained in Emergency Obstetric and Newborn Care (BEmONC and CEmONC). Surprisingly, no training on WASH was reported among facility-based health care workers (Figure 13). As expected, almost a half of HCWs assigned to RMNCAH services in the seven facilities were midwives (48 per cent). Nevertheless, there was a good number of medical officers (14 per cent) which was significantly higher than that of assistant medical officers (2 per cent) as per Figure 14.

Figure 13: Health Care Workers trained by Afya Bora project by Technical areas and Sex (n=64)



Source: Training reports, Afya Bora Project

Figure 14: Health care workers by cadre assigned to RMNCAH services in the 7 health facilities surveyed



Source: Afya Bora Final Evaluation (HF Survey)

Because of trainings and other capacity building initiatives such as mentorship and supportive supervision, HCWs and health managers admitted to have seen a positive change in utilization and

quality of RMNCAH services at their respective sites. For instance, following training for HCWs by the project, Kivunge District Hospital initiated provision of caesarean section services. Despite that, the hospital had a theatre but there were no skilled personnel to conduct surgeries. With support from the project, a surgical team of four staff was trained and received continuous support to do caesarean section. Health care workers and facility leadership at Kivunge thought that such support led to cost saving from unnecessary referrals.

> *"The hospital was not conducting C/S before the CEmONC training (by Afya Bora). We had the theatre but no one could conduct C/S. Currently, we can conduct up to 20 Caesarian sections per month. ….. The facility was using a lot of fuel to refer clients for C/S (before C/S services were made available)".* (Facility Management team, Kaskazini A)

Health care workers that attended capacity building activities by Afya Bora were considered to have better skills and improved competencies. Facility leaders and providers themselves testify to the observed change in staff capacity to effectively manage reproductive, maternal, newborn and child cases after being trained. A clinician at Nungwi PHCU+ appreciated the fact that Afya Bora trained him on medical eligibility criteria for contraceptive use, which enabled him to provide quality FP services with confidence. Moreover, the trainings enabled some cadres to start providing new services that traditionally they were not able to provide. For instance, nurses at Kivunge started providing IUCDs and implants methods of family planning, which were traditionally the services provided by doctors only. Nevertheless, it is believed that medium (3-12 months long) and long term trainings (over one-year training duration) had more impact on providers' capacity when compared with short term trainings (less than 3 months), despite that the later are likely to be more proficient in that particular area of training.

> *"…. Receiving medium and long term training leads to acquiring more competencies than going to short term trainings. (before training) Nurses were not able to provide long term methods of FP, (and) only doctors could do. But now we have nurses that are providing IUCDs and implants. All doctors now can perform MVA. Before there was only one special doctor who could perform MVA.* (Facility Management team, Kaskazini A)

> *"There is a big difference is level of competencies (after training). Those who go for shorter trainings are more "specialized" and competent in one area and less on others. However, they may be more proficient in that area than those that went for long term training. Providers with long term training demonstrate skills in more competencies and their level of clinical decision making is better.* (Facility Management team, Kaskazini A Unguja North region.

> *"… Providers are competent enough to manage normal deliveries and detecting complications in time for immediate referral. If it is an emergency, for example PPH, we do our best to manage the case, stabilizing the patient before we make referral (for blood transfusion services).* (Facility management team, Magharibi B)

> *"We (trained health care workers) have improved especially in skills and knowledge. We are (now) different…. There is a reduction in incidence of birth complications* (Maternity HCW, Nungwi)

> *"I was ignorant of issues on child development….. There was a big difference after I received that training (on child development and growth monitoring)".* (Trained HCW, Magharibi B)

While mentorship support and supportive supervision were built into the project to support trained health workers at the health facility, trained health workers in a majority of targeted facilities did not receive follow-up on support including on the job support to apply their skills and knowledge. The mentorship support on caesarean sections, whose effects are well documented by the project, provides a good example of how such support can lead to effective use of newly developed knowledge and competencies.

Finding: Support to the Zanzibar National Blood Transfusion Service (ZNBTS or Blood Bank) led to a significant increase in life saving blood donations, blood components ensuring 95 per cent of blood requests were met in 2018.

Timely availability of safe and life saving blood and blood components is a critical component in CEmONC. The Blood bank faced several challenges before the project:

- **Limited capacity for community mobilisation for blood collection.** Two approaches were used. First it depended on fixed blood collection in Unguja central and in Wete Pemba which meant continuous blood collection was limited to two districts of the two islands out of the 11. Mobile blood collection was inconsistent due to limited resources for fuel and overtime for staff involved. With Afya Bora support for allowances and transport the ZNBTS was able to expand mobile blood collection and establish satellite blood collection in two satellite sites in Pemba. The increased mobile data collection, organised in partnership with local government, also led to increased collaboration between local governments and the ZNBTS which was absent before the project. This strengthened partnership resulted in local governments assisting ZNBTS in community mobilisation and co-funding some costs related to the blood collection meetings (*Bonanza*) e.g. incentive for the blood donor. Blood safety during collection was enhanced by the procurement of the blood collection mixer by the project.

  > *"The local governments are now organising blood collection meetings in Unguja and Pemba. This is a good thing for us. Now after certain period these local government organise large groups for blood collection. Last Sunday we had a Bonanza - regional commissioner in the south district of Unguja organised a big blood collection session.*

- **Non-availability of blood components and compatibility tests**: the absence of a blood refrigerated centrifuge meant ZNBTS could only provide whole blood and therefore was unable to meet the majority of the clients' needs especially for infants who require blood platelets. The absence of a water bath also meant ZNBTS could not undertake comprehensive compatibility tests before issuing blood, which meant blood was issued without conducting compatibility tests. With support of the project in procuring refrigerated centrifuge, at the time of the evaluation, ZNBTS was processing about 95 per cent of the collected blood into blood components for blood units collected from Unguja. Other equipment such as sealers and blood mixers were improving the quality and safety of blood (reducing aerial bacteria contamination and risk of blood clots).

Because of these and other investments, ZNBTS are now able to provide life-saving blood and blood components to meet more than 85 per cent of the total demand for blood by the health system. ZNBTS was able to meet 94 per cent (15,057 units) of the estimated 16,000 units of blood requested in 2018[25].

4.1.9 Unexpected results

There were several results noted by the evaluation that were unexpected. The first was that CHVs, because the knowledge and work they were doing in the community were getting increasing recognition and higher status by communities. This has had the positive effect of increasing their confidence and motivation for the job. As a CHV put, *"we are much respected in the community, no health programme happens in the community without us getting involved. Even male leaders respect…that never happened in the past (female respondent)."* As demonstrated by the second part of the quotation, the recruitment female CHVs had a profound effect on building their confidence in a patriarchal society where women are socialised to subservient to men.

Second, because of improved quality of delivery services and ability to manage complications, husbands were more willing to accompany their wives to hospital for delivery because they were no

[25] Interview with ZNBTS officer

longer a “death trap”. Men in an FGD in Wete spoke about helplessness and not knowing what would happen to their wives as part of the reason why they would not go to the facility. They noted that since the construction and equipping of the delivery ward at Junguni, they have a guarantee that their wives will give birth and therefore are more comfortable to accompany them.

4.1.10 To what extent has the project addressed accountability and ownership of implementing partners?

Finding: Project coordination and monitoring system was established in collaboration with the Ministry of Health Zanzibar.

Right from the project’s onset, UNICEF and UNFPA worked with the Ministry of Health to establish and support various platforms for coordinating and monitoring performance of the project. This was critical in promoting sense of ownership from the Revolutionary Government of Zanzibar and other stakeholders. Some platforms involved included:

I. Afya Bora Coordination meetings: This meeting brought together members from all departments of the Ministry of Health that received financial support for implementation of Afya Bora project activities including the Transport unit, ZNBTs, IRCHP, HRH unit, HPU, Health sector reform secretariat, planning Unit, M&E, Nutrition Unit, logistic management unit (LMU), HMIS, and IMCI; and the Afya Bora implementing partners (UNICEF, UNFPA, and Save the Children). Other key stakeholders supporting RMNCAH in Zanzibar were occasionally invited to such meetings, including WHO and other international NGOs such as Jhpiego. The meetings took place quarterly, and the last meeting was for the January-March 2019 quarter. At such meetings each implementing partner including the Ministry’s departments would present progress on performance and plans for implementation.
II. Quarterly review meetings with the District Health Management Teams (DHMT): This was a platform for supporting planning and performance monitoring of RMNCAH activities at the district level. It started off with a training of DHMT members from 10 districts under Afya Bora project’s support on health management including resource mobilization, supervision, etc. Planned to happen at least twice a year in each district (scheduled quarterly in alternating districts), meetings were to be attended by DHMT members, national level MOHZ officers for respective technical areas supported by Afya Bora, and the project’s implementing partners. Members of the district presented and discussed their RMNCAH plans as well as progress towards set targets (annual targets).
III. RMNCAH Technical Working Group: Chaired by the MoHZ, quarterly RMNCAH TWG meetings received support from Afya Bora until January-March 2019. This is a national platform and less project specific with most stakeholders involved in RMNCAH implementation in Zanzibar, hence it presented a great opportunity for Afya Bora to spearhead priority issues regarding RMNCAH.

The collaborative approach adopted by Afya Bora was particularly recognized by stakeholders at national level. It was evident that members of various departments of the MOHZ were involved in planning, implementation and monitoring of project activities. Officers at both Ministry and district levels appreciated for both financial and technical support provided by UNICEF and its partners in supporting RMNCAH services in Zanzibar over the life of the project. Nevertheless, there were some reported challenges with involvement of Government officers at sub-national levels. Most of them admitted on their involvement in implementation, but less so in the planning and design of the project and informed assessment of its performance for improvement. They thought that most decisions were being made at national level, for them to be called in for implementation.

"I have never participated in actual coordination platforms. I only participated in a meeting (a few months ago) to receive updates on project performance and that the project was about to phase out". (Planning Officer, in Wete)

*"Involvement of CHMTs in implementation was good. There was less involvement of the local community (CHMT) during design of the project. Districts know best their challenges and gaps where they need support. Need to collaborate in situational analysis to prioritize areas of intervention during project development. Not involving the local authorities jeopardizes local ownership". (*A CHMT member, Wete)

*"This is the first time I see a specific initiative to evaluate this project. I haven't seen it before. There should have regular meetings to bring together stakeholders to assess progress of project's performance, review progress towards targets, and identity corrective measures. There have been project meetings but they are not specific for project monitoring/evaluation. It is likely this is done but maybe at the management/top level. But it is important to include CHMTs and even CHVs. (*Local Government official, Kaskazini A)

4.1.11 How adequate have UNICEF's and UNFPA's support been to the project, including from the perspectives of different partners at national and subnational levels?

Finding: Afya Bora is recognized for quality and technical excellence

The setup of the project implementation team that included UNICEF, UNFPA and Save the Children as a sub-contracted NGO seemed to have worked very well in successfully implementing the project. Testimonies and feedback from stakeholders and beneficiaries were generally positive regarding the quality of support received from Afya Bora. The quality was almost universally rated high by stakeholders with regard to infrastructure built or renovated, equipment procured and distributed, training of HCWs conducted, community interventions supported, national policies/strategies supported, etc. They do admit that the support from UNICEF and its partners led to a positive change.

"(UNICEF) has supported availability of life saving commodities, hence having no shortage throughout the year. If a shortage happens, it is just a fault of ordering". A CHMT member in Mkoani

"The quality of support (from Afya Bora) like building, equipment and training are of a high value". (A HCW, Pemba)

"The quality of equipment and training are good and helpful" (Facility in charge, Wete)

"The quality (of support from Afya Bora) is good. For example, people are comfortable with the environment (infrastructure) and the quality of services they receive. That is why we see increasing number of clients every year". (Facility management team, Magharibi B)

Finding: Awareness of the project's brand diminishes at sub-national level.

Afya Bora was a UN joint programme between UNICEF/UNFPA and the Revolutionary Government of Zanzibar with Save the Children as the contracted NGO to facilitate implementation of the community health component. However, Afya Bora as a brand was not well known among stakeholders particularly at sub-national levels. Partners of the project were recognized by their specific roles, such as Save the Children for community interventions and UNFPA for infrastructure, equipment and training of HCWs. It was challenging during the evaluation field mission to directly associate the project's achievement and/or support with the project "Afya Bora". In a few instances some stakeholders were only able to recognize support from the project by identifying individual project officers whom they usually met during implementation. Besides, not all items donated by the project had an Afya Bora sticker on them. Thus, there was a challenge with proper branding for the project, which may have led to underreporting of Afya Bora's achievement during this evaluation. For future

initiatives, it will be useful to have a clear project-branding plan and ensure that all implementing partners follow the same.

> *"Not sure whether the support is from this project, but we have received support from some projects including; Equipment, Supplies, and infrastructure improvement" (*CHMT member, Mkoani)

> *"We would like to thank the organization ….. not sure which one, I don't know if it is UNICEF that you mentioned… they trained community workers who educated our community".* (Religious leader, Kaskazini A)

Equity and Gender Focus

4.1.12 To what extent have the project design and interventions taken into account the most vulnerable and hard to reach populations?

Finding: From the onset, building equity in the health system was a primary objective of Afya Bora but challenges still remained.

The project identified strategically located health facilities to provide quality 24/7 basic emergency obstetric and new-born care for deprived and less served remote areas of Unguja and Pemba. These were PHCUs with poor infrastructure, large catchment areas and no BEmONC services. One of the facilities, Junguni, only had one small room for delivery while at Uondwe another PHCU upgraded by Afya Bora had no delivery rooms. For Uondwe particularly, women have to walk long distances to reach the district hospital for delivery services, resulting in most mothers delivering at home. In turn, high maternal and neonatal deaths ensued. CHMTs in all districts were in agreement that the selected facilities were among the most affected in the districts.

While financial investments in selected PHCUs by Afya Bora was to ensure availability of BEmONC services, the need was much greater than could be met by Afya Bora alone, which in some cases, undermined the availability of intended services at certain times. In Uondwe, for example, staff were not resident at the facility as there was no staff accommodation. This meant that despite the investment in delivery and BEmONC services, it was not offered on a 24/7 basis as envisaged. Other equipment placed centrally such as the ultrasound machine were not reaching all island shehias. It was suggested that there be specific ultrasound machines for those areas. On its part, Afya Bora procured the first ever ambulance boat for use in Pemba, Wete, and specifically for these island Shehias. This was a first even for UNFPA which undertook procurement of the boat demonstrating commitment of the project to ensuring equitable access to services.

CHVs were placed in all the rural districts of Pemba and Unguja. However, placement did not take into account size or geographic distribution of the population. In Wete, Kodiani and Fundo comprise multiple islands which are difficult to reach all target groups. Makongeni (large Shehia with population sparsely distributed), Uondwe (large population with about 1000 under five population) have the same CHVs as compared to other Shehias such as Junguni. The procurement of the ambulance boat aimed to address this challenge in Pemba.

Finding: Health outcomes in Pemba's districts are worse than those in Unguja's districts but resource allocation for the project did not consider this important characteristic of the two districts.

There is remarkable geographical variation in RMNCAH outcomes between Pemba and Unguja which is an indication of inequity in service coverage. The End of Project Report for Afya Bora noted an increased stillbirth rate by 28 per cent from 21.3 deaths per 1,000 births to 27.3 deaths per 1 000 births in Pemba compared to only 8.5 per cent increase in Unguja (from 18.8 to 20.4 deaths per 1,000

births between 2017 and 2018. Table 9 provides the status of various RMNCAH indicators for Pemba and Unguja. Pemba consistently performs below Unguja.

Table 9: Summary of performance of RMNCAH indicators in Unguja and Pemba

Indicator	Target One Plan	Zanzibar	Unguja	Pemba	Source
Modern contraceptive prevalence rate		14%	16%	9%	TDHS 2015/16
Unmet need family planning		28%	24%	36%	TDHS 2015/16
Demand for family planning		51%	53%	47%	TDHS 2015/16
Teenage pregnancy		8%	7%	11%	TDHS 2015/16
Institutional delivery		66%	75%	51%	TDHS 2015/16
Caesarean section rate (WHO)	5%-15%	6%	8.3%	2.1%	TDHS 2015/16
Use magnesium sulfate to treat eclampsia		19%	15%	23%	TSPA 2015
Golden minute newborn resuscitation performed by HFs		37%	48%	28%	TSPA 2015
Children aged 12-23 months received all basic vaccinations		81%	81%	80%	TDHS 2015/16
Children with acute respiratory infection received antibiotics		53%	43%	66%	TDHS 2015/16
Children with fever who took antibiotics		50%	55%	41%	TDHS 2015/16
Children with fever who took antimalarial		2.4%	2.3%	2.6%	TDHS 2015/16
Under-five stunting (height for age)		24%	20%	30%	TDHS 2015/16
Under-five wasting (weight for height)		7%	6%	9%	TDHS 2015/16

Source: MOHZ (2018) Zanzibar Reproductive, Maternal, Newborn, Child and Adolescent Health Strategic Plan (2018 – 2022)

These differences in outcomes are a direct result of the status of RMNCAH services including BEmONC and CEmONC services in Pemba and Unguja. While Unguja had access to blood components (including infant packs), Pemba only had access to whole blood due to lack of decentralisation of this capability by the ZNBTS. Again, Pemba only had one blood mixer serving the entire island, which compromised the consistent availability of quality and safe blood. The main reason for this inequity in service provision was given as the inadequate funding available which led to a focus on Unguja because ZNBTS had not fully decentralised.

Resultantly greater investments were required in Pemba than in Unguja. This is in line with the Mid Term Review of the Health Sector Strategic Plan for 2013/2014-2018/2019 as well as the Zanzibar Health Strategic Plan 2018-2022) which note the need to increase investments in specific zones in Pemba to improve RMNCAH indicators for Zanzibar.

Finding: The project design recognised the importance of targeting adolescence including key indicators. However, there were some gaps in implementation.

Afya Bora planned to reach 100 000 adolescents. The key outputs for adolescents were *"Increased number of pregnant women, caregivers of children under 5 years old and adolescents participating in promotional health, WASH and nutrition services"* and *"Strengthened youth friendly SRH/FP service provision in selected districts"*. Some of the planned activities were:

- Realization of educational sessions on RMNCAH, WASH and nutrition for adolescent boys and girls in 300 primary and secondary schools.
- Provision of promotional RMNCAH, WASH and nutrition services by CHVs to pregnant women, mothers/caregivers of children under 5 and adolescents through SBCC (group counselling, cooking demonstrations, home visits).
- Promotion of RMNCAH care seeking behaviour to pregnant women, mothers/caregivers of children under 5, adolescents through SBCC and supply of ORS, iron-folate tablets and condoms.
- Refurbish facilities for the provision Youth Friendly Service (YFS)

In accordance with the project's design, adolescents were mainly targeted through community health promotion initiatives mainly implemented by CHVs. However, CHVs were ill equipped to handle adolescents. For example, one key informant said, *"As we speak to CHVs and supervisors they have requested the need for more materials for adolescence. Adolescents want information and therefore an important area to look at in training CHVs".* The link between community health promotion including referral to Adolescent and Youth Friendly services (AYFS) was absent in the project areas.

The project constructed youth friendly spaces in selected facilities such as at Nungwi in Unguja. However, the limited referral of adolescents by CHVs is undermining utilisation of this investment. Another issue is the training of staff in youth friendly service provision, which was lacking for staff interviewed at Nungwi for example. This again will have a negative impact on utilisation by adolescents.

Access to RMNCAH services by adolescents was also difficult to measure as data is not disaggregated by age. This makes evidence-based planning a challenge, further undermining access of adolescents and youth to SRH services.

4.1.13 To what extent have sex and disaggregated data been collected, monitored and analysed to inform the project?

Finding: Despite some initiatives to enhance gender responsiveness of some interventions, there was no coherent strategy for incorporating gender in the project. This remained a weak point in project design and implementation.

There was no strategy to respond to specific gender issues undermining RMNCAH in Zanzibar which were recognised in the situation analysis of the project proposal. The result of this was non-systematic integration of gender in project implementation. The evaluation recognises the changes made by the project including introduction of male champions in the CHV programme to specifically target men and attempts to make infrastructure more gender sensitive e.g. the attempts to adopt cubicles for female wards, successful in Malawi, to encourage male participation. More benefits could have been derived by including gender mainstreaming in the design. For example, technical support could have been provided to government engineers on gender responsive infrastructure for them to appreciate its importance for RMCAH outcomes. Targets for male involvement and approaches beyond male champions could have been employed to ensure increase in male involvement in RMNCAH.

Finding: Sex disaggregated data was only provided for CHVs, reach of CHVs and support to health workers and missed out some critical indicators.

Sex disaggregated data is provided for persons reached by CHVs, CHVs in post, and trained health workers. Beyond this sex-disaggregated data is not provided for example: infant deaths, growth monitoring and nutrition services etc. Limitations in availability of sex-disaggregated data are due to several factors including:

1) the absence of a clear gender outcomes in the project document and in turn relevant indicators;
2) the DHIS database, the main data source for the project's monitoring framework has no provision for gendered analysis of these outcomes; and
3) capacity of the MOHZ's M&E unit to undertake such analysis is limited.

Efficiency

Efficiency in this evaluation was limited to: *"To what extent have the project management and coordination been efficient?"* To answer this question this explores the following issues:

1. Level of functionality and effectiveness of national and subnational coordination platforms;
2. Staffing levels vis a vis the project's scale and objectives;
3. Platforms that exist for lessons sharing between partners and the benefits accruing;
4. Monitoring systems put in place, their adequacy to provide information required for project management and how information from the monitoring system was used for project steering at all levels;
5. Key drivers and constraints to coherence and coordination.

Below are the main findings.

4.1.14 Level of functionality and effectiveness of national and subnational coordination platforms

Finding: An effective national coordination framework for the project was established and was functional.

The project supported the strengthening of the RMNCAH Technical Working Group located in the Ministry of Health with the responsibility to review progress on projects being implemented under the ministry to improve RMNCAH in Zanzibar. The working group, chaired by the Director of Preventive Services, is an inter-sectoral coordination platform at the national level that holds quarterly review and planning meetings. The platform provides *"an opportunity for dedicated technical teams to discuss emerging evidence, technical challenges and best practices identified during maternal and perinatal death reviews at the zonal, district and health facility levels, as well as to discuss other RMNCAH interventions including, but not limited to, voluntary family planning and post-abortion care."*

Support given to the Ministry of Health to strengthen RMNCAH Technical Working Group recognises the best practice of "embedding the project's coordination within the existing government coordination structures" and conforms to the Paris Declaration on Aid Effectiveness Alignment principle where support is aligned to the country's strategies and using local systems.

The evaluation found the TWG functional and providing guidance to RMNCAH. Afya Bora was an integral part of the TWG discussions (including a set agenda on Afya Bora progress) and thus was embedded in the planning systems of MOHZ. It also notes the role of the coordinative platforms in acting as vehicles for the development of national plans for the realisation of the government's objective to improve the reproductive maternal and new-born and child health. The following were developed during the project period:

- Zanzibar One Reproductive, Maternal, New-born, Child and Adolescent Reproductive Health Strategic Plan (2018 – 2022), integrating multiple interventions of all stakeholders;
- Zanzibar Multi-sectoral Nutrition Action Plan (ZMNAP) July 2019 – June 2024;
- Revised Community Health Strategy including CHV programme as a national platform; and
- Zanzibar Family planning Costed Implementation plan 2018-2022

"Management approach of the project. Because UNICEF work together with the MOHZ and plan together and this approach (technical sharing) drive us to the success. We participate in the meetings of Afya Bora and the whole team is invited. The approach to management therefore is the basis of success." (An officer of Zanzibar National Blood Transfusion Service (ZNBTS))

In addition to the RMNCAH TWG, an Afya Bora project specific coordination committee was established and included all MOHZ departments that received support under the project together with the two UN partners (UNICEF and UNFPA) and UNICEF's sub grantee Save the Children. The coordination committee met every quarter for the duration of the project. Other partners such as the World Health Organisation, Jhpiego, and International NGOs implementing RMNCAH activities were occasionally invited. The meetings enabled all stakeholders to understand progress, challenges and co-produce solutions for bottlenecks.

Finding: Coordination of Afya Bora at national level represents good practice for UN joint programmes.

The success in coordination was reflected in how the two UN agencies collaborated and used their comparative advantages to deliver comprehensive support. There was clear division of labour between the agencies, and by operating in the same facilities and communities, they were able to bring comprehensive support at the facility and community level that neither agency would have provided alone. Another example, is the support on SRH and family planning provided to CHVs under UNICEF by UNFPA in order to enhance SRH and family planning that was weak from design. This represents a good practice for UN joint programmes.

Finding: RMNCAH coordination at district level was improved but district coordination of Afya Bora was non-existent and needed to be improved to enhance transparency and accountability at this level.

At the district level, Afya Bora worked to strengthen RMNCAH coordination through strengthening DHMTs. It provided training and funding for quarterly meetings. It was clear coordination of RMNCAH had improved in the districts with quarterly meetings involving key stakeholders in RMNCAH in the respective districts.

"We have coordination meeting with RMNCAH stakeholders, including community leaders, TBAs, CHVs etc. They are usually scheduled for quarterly, but they may happen only once or twice a year depending on availability of funds". (CHMT member, Mkoani)

On areas of improvement, one CHMT chair indicated, "*There is need for training and technical updates. CHMTs are supervisors, but sometimes they are more outdated than HCWs that they are going to supervise."* There is evidence to suggest CHMTs are functional on the whole, however there are still challenges on effectiveness in terms of oversight and coordinating all relevant activities at the district level, financial resources have been sighted as a constraint to enable reviews and planning meetings to be done at the level. It is not clear on the level of detail of reports generated on progress and challenges in project implementation. There is still need for clarity on the volume of data and information that could be shared at this level, the mandate of the CHMT and the decisions taken at their level on the project, the flexibility of the system to give space to CHMT.

There were no specific coordination structures for Afya Bora in all districts. District level stakeholders noted that they were only engaged in implementation and not the planning of Afya Bora activities in their respective districts. As highlighted in the effectiveness section, it was difficult for district stakeholders to distinguish Afya Bora support. Only the CHV programme was synonymous with Afya Bora with Save the Children being the visible partner as they held quarterly meetings between the CHMT and CHV supervisors. When asked on whether they had received timely support or whether what they received was in accordance with their expectations all CHMT members met could not inform these questions as they were not privy to the work plan or what was planned to be delivered by the project in their districts. Lack of involvement of districts in planning and informing activities of Afya Bora affects ownership and support of project's initiatives. To enhance this aspect, considerations could have been made to ensure Afya Bora was a standing agenda item for CHMT meetings and not necessarily a separate structure,

"It was timely by considering the issues in project plans. However, the project didn't always respond to the needs of the CHMT at that time. Hence, there is a need for improved involvement of CHMTs in planning of activities." (CHMT member, Magharibi B)

"This is the first time I see a specific initiative to evaluate this project. I haven't seen it before. There should have regular meetings to bring together stakeholders to assess progress of project's performance, review progress towards targets, and identity corrective measures. There have been project meetings but they are not specific for project monitoring/evaluation. It is likely this is done but maybe at the management/top level. However, it is important to include CHMTs and even CHVs." (CHMT member, Kaskazini A)

The sentiments by CHMTs above are important observations that recognise the importance of clearly defining the role and mandate of lower structures and how their views could be captured and considered in making decisions on actions taken to support the project.

4.1.15 Monitoring systems for the project

The project used several MOHZ embedded monitoring systems to support evidence based RMNCAH planning and service delivery and inform progress on the project including:

1. District Health Information System 2 (DHIS2);
2. Facility Assessment and Accreditation (Star Rating);
3. Maternal Perinatal Mortality Surveillance and Response (MPDSR) systems;
4. Monthly and quarterly reporting by CHVs; and
5. Monitoring visits.

Finding: The project worked with the existing health information system to monitor project performance, with some concerns on data quality.

Most of the results attributed to the performance of the Afya Bora project were based on service coverage and health outcome indicators as captured through the routine Health Management Information system. It is a strategic investment for projects like Afya Bora to work with the national HMIS as that strengthens the system including human capacity. Although there were no specific M&E review meetings reported during the evaluation, it was evident that M&E and data use was integrated into various project coordination and progress review meetings. The main concern however is the quality of data at various levels of the health system. It was revealed to the evaluation team that documentation right from the data source (health facilities) was of poor quality. For the seven health

facilities that were visited it was mostly difficult to get hold of data related to services provided at respective health facilities. For instance, none of the facilities had data on maternal, newborn and child referral cases received even in recent years. Health facilities admitted to not collect/keep the data, whereas some of them reported to rely on CHVs reports for the same information. Besides, it was challenging to obtain data from the national DHIS2/HMIS for national aggregated RMNCAH indicators which took longer than expected. The previous DHIS2 system was reported to have collapsed, hence it required a great effort from one of the HMIS officers to be able to extract data for years before 2018. Moreover, some project indicators could not be informed with the available data from national health information systems. While the Afya Bora revitalised the HRH information systems it was still at early stages of implementation at the time of the evaluation and data on human resource for health was not readily available.

Oversight on staffing and utilisation of training skills and knowledge, utilisation of equipment provided, improvements in quality of care were aspects missing from the monitoring system for Afya Bora. These could have benefited from a broader project specific M&E system that maintains the advantages of using national systems but puts in place measures to address project specific information needs.

> *"Looking at coverage indicators on quarterly basis (at district level). There is a need to have tools specific for monitoring project performance."* CHMT member, Wete District

Understanding the importance of reliable data sources for project's monitoring and evaluation, more investment could have been made to strengthen the health information systems as well establishing systems for indicators in the performance framework of the project but not within the remit of national systems. Having reliable and quality data would be used to inform decisions and accountability among implementing partners, LGAs and the MOHZ.

Finding: Strengthening of the MPDSR had a significant contribution to the improvement of RMNCAH service delivery.

The project facilitated establishment and strengthening of the MPDSR at central, district and facility levels as a tool for continuous quality improvement of maternal and new-born health care. The support given to establish and strengthen MPDSR included development and operationalization of MPDSR guidelines and tools to harmonize death identification, reporting and review from community to health facility levels. To strengthen the supply side of health services, technical and financial support was provided for MPDSR at hospital, district and zonal levels including support on implementation of recommendations made from these reviews. The provision of guidelines and tools was an important part of the project, and with support to make sure service providers understand the tools and guidelines and develop capacity on how to use the tools. It was not possible to ascertain the quality of the data generated and collected in the field, as well as the analysis of the data for purposes of reporting progress and challenges.

The conceptualisation of MPDSR and its set up is to develop a structure that generates evidence and produce reports to be reviewed by a committee to identify causes of maternal and newborn deaths and formulating solutions and resourcing the implementation of recommendations made from reviews. We understand the thinking behind MPDSR is establishing a unit that is well resourced in terms of collecting data, conducting data analysis and reporting, once the committees reviewing data and reports accept recommendations, these could immediately be operationalised.

The project facilitated the setting up of MPDSR committees in the 44 maternity facilities, in 11 DHMTs, pre-service training institutions and health teams at the zonal and central level. This is significant progress, however it is the evaluation's view that additional work is still needed to develop capacity

of committee members to ensure that all maternal and perinatal deaths are recorded, data is available for review at the committee meetings, and checking the quality of the data and the timing of its availability. Given the committees are at different levels from the facility up to the national level, modalities of reporting at the different stages, the detail of the data as it goes up the ladder has to be decided to ensure relevant information filters to the national level for strategic decision making.

Additional training support in Bottleneck analysis was improving identification of challenges in the delivery of RMNCAH services and districts as was agreed by the Wete CHMT that, *"We knew nothing about Bottleneck analysis (BNA) – after training and support we are now knowledgeable and are able to do it. We use BNA to identify disparities and finding solutions. We then consolidate this in the consolidated national plan."*

Finding: Facility assessment and accreditation (Star Rating) not only led to improvements in availability of minimum package of integrated RMNCAH services, but enabled the project to determine progress in availability of services at health facilities.

According to the End of Project Report for Afya Bora, facilities with "0" star rating (no service) decreased from 59 to 16. Those with two stars increased from 2 in 2017 to 45 in 2019 while five facilities had three stars by 2018 from 0 in 2017. While the main purpose of the accreditation system was to spur health system wide service improvements it also provided to the project, information on the status of service delivery in targeted facilities against those not supported by the project especially at PHCU level. This information would enhance project implementation including determining how the project was improving equity in the health system. While the Star Rating system afforded immense opportunities for performance monitoring of the project, it was not clear how the project took advantage of this as monitoring reports do specify how Star Rating data is used by the project.

Lastly, Save the Children collected monthly and quarterly reports on CHV performance allowing Afya Bora to closely monitor areas of underperformance. Additional, visits to project sites though not systematic helped UNICEF and UNFPA staff to appreciate project implementation on the ground.

4.1.16 Staffing levels vis a vis the project's scale and objectives

Finding: Whilst Afya Bora has successfully achieved most of its targets, this has been possible because of the operational staff, the health workers and community health volunteers at the facility levels. There is potential to achieve more with levels of staff increased and their skills and competences enhanced.

The setting up of national coordination platforms was a key objective for RMNCAH. These were a means to an end − providing leadership at various levels to lead and manage the implementation of the RMNCAH through the development of plans. To complement the work of the national coordination platforms, the Revolutionary Government of Zanzibar managed to recruit and retain staff to operationalise their respective plans. This section of the report presents findings on capacity in terms of staff to implement RMNCAH programmes to meet the government objectives.

There were major constraints that have been documented relating to inadequate quantity and quality of RMNCAH Human resources for cadres at all levels of service delivery. The 2017 health situation analysis established that The Zanzibar RMNCAH health workforce density is estimated at 6.3 per 10 000 population. This is well below the WHO recommended threshold of 23 core health workers per 10 000 population in order to achieve 80 per cent of births attended by skilled personnel. There are large disparities in the distribution of health workers in Zanzibar with noted shortages in Pemba. Consequently, there is a high likelihood that Zanzibar will continue to struggle to provide skilled care

to a significant number of pregnant women, as well as emergency and specialized services for new-born and young children.

The project has adopted multiple approaches to improve the quality of human resources at health facilities from the district to the national level. These include medium to long term staff development programmes for key personnel. Training of five Obstetrician Gynaecologists and nine midwives to attain a Master's Degree in Midwifery, improving the quality and level of pre-service training for nurses and midwives, in addition to building in-service capacity, support has been provided to improve pre-service midwifery education.

Whilst these measures could result in improvement of staffing in key positions to deliver RMNCAH, there is high risk that those being trained might not be retained in the long term because of poor conditions of service. Risk will only be reduced if the terms and conditions in the health services are addressed. The expectation of partners is for the government to take lead in the recruitment of staff at all levels to ensure functional health facilities. The successful CHV programme to promote demand for RMNCAH is not adequately matched with increase in the number of staff in health facilities to ensure supply of services.

The results of facility accreditation process showed that *"majority of the facilities (75 per cent) were performing poorly scoring only one or two stars (out of a maximum five) due to poor quality of services especially in maternal and new-born care. Most facilities had weak organisational structures making them unable to deliver the full essential health packages and poor preventive maintenance of equipment and supplies was commonplace"*[26]. This is mainly due to poor staffing levels, limited skills and competencies of facility leadership, health and support workers.

The evaluation noted that retention mechanisms for staff have yet to be developed and their absence posed a high risk to the functionality of health facilities and jeopardise the ability of the government to improve RMNCAH for its citizens post Afya Bora.

Finding: Project staffing in implementing partners may have been inadequate for the scale of the project.

Capacity of UNICEF and UNFPA was well recognised and appreciated by stakeholders. UNICEF and UNFPA both provided technical specialists to oversee the project in their Zanzibar sub-offices. Implementation was undertaken by Save the Children (for the CHV component) and MOHZ. It was evident that staff of both MOHZ and Save the Children had strong commitment to the project but were overwhelmed by the scale of the project. The project had one focal person in MOHZ who was also responsible for other activities within the ministry. The demands of Afya Bora and those of MOHZ overstretched existing staff leading to delays in some cases. Given its scope and investments, it may have been necessary to include a full-time project staff at MOHZ level to help with coordination of project activities. We note that Save the Children had 30 per cent budget cuts which adversely affected staffing expected to be in the field. One informant of Save the Children had this to say, *"In 2016 we were six staff. One in Pemba and a driver and community mobiliser, officers and a male person. Due to the cuts were left with three staff with none in Pemba. Much of the work relies on community participation and engagement - have to be in the field so we are forced to attend to the field, do admin issues attend meetings and part of the TWGs, a bit overwhelming".*

Sustainability

Finding: The Revolutionary Government of Zanzibar and its agencies appreciate best practices from Afya Bora project and intends to continue supporting them.

[26] Afya Bora Annual Report 1 APRIL 2017 – 30 APRIL 2018

The Afya Bora project was intentionally designed to support the RGoZ in addressing challenges in Reproductive, Maternal, Newborn, Child and Adolescent Health. The project deployed innovative interventions both in the supply and the demand side of the health system. Such initiatives have contributed to a positive change in the lives of mothers, newborns, children and adolescents. Almost universally, stakeholders working for Government institutions at various levels expressed the need and commitment to continue with project's best practices beyond the project's support. For instance, following recognition of work by CHVs, the Ministry of Health decided to establish the "National CHV Programme" to be scaled up across all districts in both Unguja and Pemba. This program adopted a number of strategies and CHV materials developed and used under the Afya Bora Project. Despite that this program will still be financially and technically supported by other partners (in this case DTree) implementing partners, the plan is for the Revolutionary Government of Zanzibar to take it over after some time. Some districts are expecting to be able to allocate budgets to sustain the such promising initiatives. Nevertheless, there are stills concerns whether the RGoZ will have enough resources to support and sustain such interventions without donor support. Accordingly, the Government's commitment to sustain best practices from the Afya Bora project will only be realized if there are adequate resources to meet the budget.

> *"…. The deployment of CHVs (should be sustained). We have learned that this system works. And we are committed to continue this practice to maintain the performance we see today".* (Local Government, Magharibi B)
>
> *"…….. Motivation of CHVs is also another initiative to sustain…. Incentives (stipend for CHVs) will be continued (paid) by the local government".* (CHMT member, Kaskazini)
>
> *"….. Most activities will continue. For example, with CHVs the materials used with the national programme are similar to what was used under Afya Bora".* CHMT co-opted member, Magharibi B
>
> *"With establishment of a national CHV cadre, will sustain community engagement provided that the MOHZ will have a budget to support them. …. with no stipend for CHVs, it is less likely to receive performance reports"*. CHMT member, Wete
>
> *"Stipend for CHVs will be a challenge. There are some that will be willing to work on purely voluntary with expectation of future opportunities. But also there are some CHVs who will not be able to continue working with no stipend".* Local government, [place]

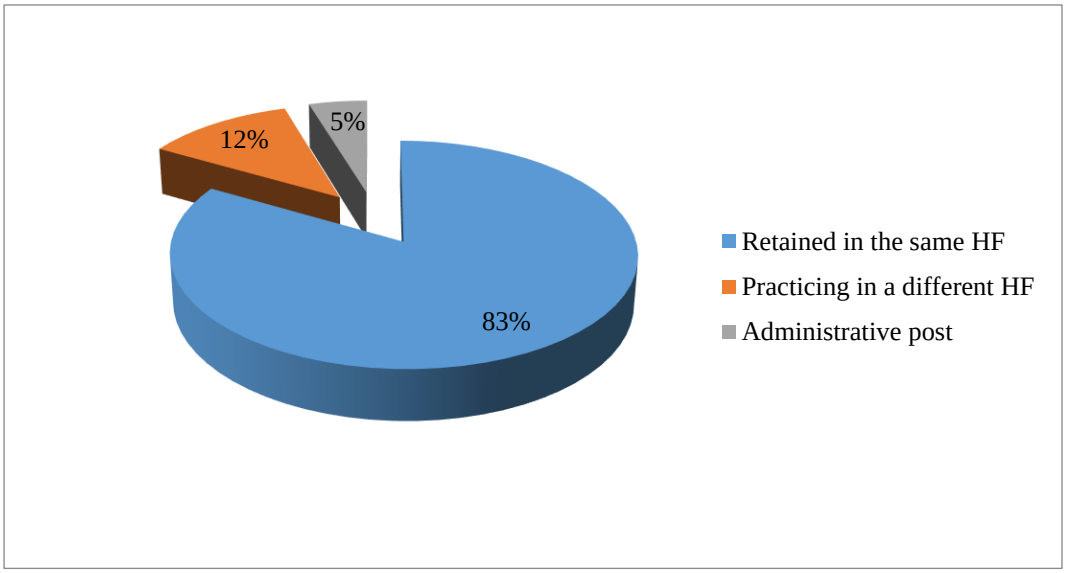
Finding: The project invested in strengthening pre-service training in Midwifery

In addressing the challenge of quantity and quality of human resource for midwifery services, the project deliberately invested in strengthening pre-service midwifery training in Zanzibar. This investment is likely to contribute to sustainable production and deployment of competent midwifery workforce in the islands. When competent graduates are deployed, they are expected to contribute to good health outcomes by implementing life-saving practices and demonstrating professional behaviors. For high-quality pre-service education, both the quantity and the quality of midwifery educators/tutors are crucial, parallel with necessary improvements in the resources (good teaching infrastructure and skills laboratories for skills acquisition) and capacity of health training institutions in which they work. This is exactly what Afya Bora worked on by providing support to the Zanzibar College of Health Sciences of the state University of Zanzibar (SUZA), including: new 9 tutors trained in masters of midwifery; equipping the skills lab; providing learning materials to the laboratory; and developing tools and guidelines for clinical instruction and assessment.

Finding: The project built capacity at service delivery sites to sustain RMNCAH and Nutrition services.

Through various trainings conducted by the project, health facilities and communities have human resources that can sustain some high impact interventions in RMNCAH. The project's approach highlights how capacity development can be transformative by changing practices in a positive way. For instance, all providers that were supported for medium and long term trainings came back to work for the MOHZ whereas 95 per cent of them are still doing clinical work (Figure 15). This could mainly be attributed to a well-managed process by the Ministry of Health to ensure retention of trained HCWs including a contractual bonding between the Ministry and HCWs who had to receive long term trainings. Besides completed trainings, stakeholders reported on the project's continued involvement in continuous learning for improvement such as QI assessment and ongoing skills practice. Officers at the Ministry as well as health care workers at supported health facilities believe that they will continue providing services banking on the skills and competencies they received with the project's support. Nevertheless, health care workers expressed the need for increasing the number of qualified staff as well as receiving regular technical updates through training and/or mentorship.

Figure 15: Current roles of HCWs who received medium and long term trainings under Afya Bora (n=42)



Source: Training and staffing reports, MoHZ

MOHZ is currently implementing the new community health strategy that includes CHVs as a central part of the strategy. This includes recruitment and training of new cohort of CHVs. At the time of the evaluation recruitment had been completed in Wete but not all existing CHVs were retained. Thus, while CHVs as a structure will continue, the capacities developed by the project will not be fully retained.

Finding: Existing lack of clarity of roles and weak coordination of actors at various levels may undermine efforts to sustain the gains in RMNCAH and Nutrition services.

Decentralization by devolution started to be implemented in Zanzibar in 2017 whereas the Primary Health Care Sector was decentralized in 2018. The process aimed at empowering local Governments to coordinate and deliver services more closely to the communities. Local Government and Health Managers at Council level reported that the decentralization process was less disruptive and did not affect activities of projects like Afya Bora. Nevertheless, evidence was gathered during interviews demonstrating that officers at both national and sub-national levels are still in transition regarding understanding and implementing the decentralized system. Before decentralization it seemed that the project worked very closely with technical officers at the Ministry level in charge of various

components of the project such as nutrition, health promotion and community programs, etc. However, with decentralization, where most activities are managed from the council level, technical officers at the Ministry level are relatively less engaged which may affect the level of technical oversight during implementation. For example, CHVs are overseen by HPU however, HPU staff are not permanent members of the CHMT yet the CHMT is responsible for financing operations of CHVs in the decentralised system. Further departments such as nutrition are also not part of the CHMT as permanent members. This structural arrangement was causing gaps in financing and coordination in some instances. For example, HPU and nutrition staff, reported to be less involved in planning and budgeting of activities as well as in implementation. Since these are the same people that were closely involved with implementation of specific project activities, their lack of involvement going forward may lead to loss of institutional memory. Besides, some members of the health team at the council level (CHMT) thought they were less efficient with the decentralized system. They admitted that it was not clear how they were supposed to work and/or be supported at the council level to meet their targets for health programs. Nevertheless, decentralization by devolution seemed to be the right approach as it enables local authorities to identify and address context-specific health challenges including in RMNCAH. Accordingly, there is a clear need to strengthen coordination and collaboration at various levels in line with the decentralization concept to enable sustainable implementation of RMNCAH and Nutrition activities.

> *"Decentralization started in 2017. There has been no effect on how implementation is done. Members of the council have the same responsibilities". (*Local Government, Wete)
>
> *"Decentralization started in 2017 in July. There have been no significant changes. It is only change in name from DHMT to CHMT. …….. There is no any effect to the implementation of projects like Afya Bora. The only change is the HPU (Health promotion Unit) coordinator is now based at the Ministry, and supports the district when needed". (*CHMT member, Magharibi B)
>
> *"Before decentralization, focal persons (technical officers at the Ministry) were working more closely with DHMT members since they were both part of the MOHZ. With decentralization, there is a bit of weak linkage with CHMTs since they* now *belong to two different ministries i.e. CHMTs are under the local Government, whereas focal person is still under the MOHZ… They don't usually plan together. . …….CHMTs would invite a focal person when they have a need for support" (*CHMT co-opted member, Kaskazini A).
>
> *"There is poor recognition of technical focal persons from the MOHZ by the councils. Focal persons are not involved in council level planning. Even after the plan is developed focal persons are not oriented on the plan for efficient coordination. Instead, the focal person is "invited" to participate in activity based undertakings". (*CHMT co-opted member, Magharibi B)

Finding: Financial constraints have an effect on implementation and oversight of RMNCAH services.

All great initiatives that led to remarkable results under Afya Bora involved financial support from the project. The major concern on sustainability from almost all stakeholders interviewed was on availability of financial resources. There was no clear exist strategy however on how the Revolutionary Government of Zanzibar will be taking over project-sponsored activities after Afya Bora ends. Some initiatives for example had already "stopped" after Afya Bora and/or its partners ceased providing support; leading to fewer supervision visits, fewer district performance review meetings, etc. With decentralization it is expected that councils will be financing such activities. However, councils admit that there are so many priorities and resources are scarce. CHMTs were of the opinion that their activities and budgets were not prioritised when other council business is considered and therefore they depend heavily on external support.

*"There is still a transition process after decentralization. It is challenging for CHMTs to execute their core functions due to lack of facilitation e.g. transport for supportive supervision…… It is not clear whether people at various levels understand how decentralization works ….. We feel like our functions are not well known to the municipal leadership". (*CHMT member, Magharibi B)

"The allocation (of council budget) is based on needs. CHMTs receive inputs on needs from health facilities and community health committees. Also (we) consider Ministry policies and guidelines regarding health priorities. ……. The budget is not enough. Only about 50 per cent of (our) needs are met" (Local Government official, Magharibi B)

"(We are) not sure if the Government will afford to sustain all activities that have cost implications". (CHMT co-opted members, Kaskazini A)

"UNICEF through Afya Bora used to support the HPU with fuel to facilitate supervision of community activities. This was stopped about 3 years ago…… At the unit level, there is no budget to support focal persons activities including supervision, providing health education, etc". (CHMT co-opted members, Magharibi B)

Finding: Inadequate involvement of some local actors in critical stages of the project may undermine ownership and sustainability of project-supported activities.

Effective involvement of key stakeholders at various stages of the project cycle are key not only to successful implementation but also ownership and sustainability of project-supported activities. Afya Bora was highly commended for its close collaboration and working relationship with national level departments at the Ministry of Health. Stakeholders at district and facility levels also acknowledged being part of the project but mainly during implementation of activities. There were universal concerns regarding participation of district health managers and health facility leaders in the design of the project, prioritization and planning of project activities in their local sites. They recommended in future for similar projects particularly the high-level project leadership to prioritize working with stakeholders at district levels the same way they collaborate with Ministry level departments. Nevertheless, they commended the level of support received from the project and acknowledged that they were being informed on the progress of the project.

"There has been a challenge with planning and coordination at district level. When the project started was working more with the MOHZ at central level. We usually meet in activities but there is less planning and coordination meetings with district authorities, including the district Director, and District Commissioner. All these leaders need to know what is happening in their own district, even if the permission has come from the ministry. Partners should go and introduce their activities to these leaders. It is possible this was done before I joined (the CHMT) in 2016 but for the (period of) time I have been here this has not been done. When district leaders are involved they are likely to be supportive in case of any challenges" (Local Government official, Kaskazini A)

"DHMT members were involved right from the beginning (of execution) including introduction of the project. Joint planning……. There was regular feedback at all levels ….. DHMT (members) should be involved in the design of any follow up project". (CHMT members, Kaskazini A)

"The support we got is for the new building and (some) modern equipment for the RNMCH Services…. Unfortunately, I did not get involved in deciding which support we needed to address RMNCAH services". Facility management team, Wete

"The project structure and team are not well known at the district level. We know few officers that are involved with direct implementation at local level. In case of underperformance of implementation officers, we don't know who to contact for feedback. Senior project managers should have been visiting districts to familiarize with district leaders. I believe the project management is known at the level of the MOHZ (central level). But the same kind of introduction should be done at district level". (Local government official, Kaskazini A)

"Support we got from Afya Bora Project were equipments and trainings, unfortunately I was not involved in deciding which support I needed to address RNMCH (challenges) at this facility". Facility head, Wete

"…….. The facility was not involved (in the design of the project)". (Health facility Management, Wete)

"We don't see CHMT being able to maintain the coordination of CHVs program. CHMT has not involved itself in management of CHVs. They have just been receiving reports. Responsible focal persons, e.g. for health promotion, are not in the decentralisation (structure), i.e. they are not core members of CHMT. Probably they could have supported the initiative". (CHMT co-opted members, Magharibi B)

Finding: Availability of updated policies, strategies and protocols in RMNCAH will sustain quality in RMNCAH services.

During the period of Afya Bora support, the Ministry of Health Zanzibar developed and revised a number of national policies and strategies to guide RMNCAH services in the islands. Some documents developed with Afya Bora support and/or involvement included:

1. The Zanzibar FP costed implementation plan (2017-2020), launched in 2018
2. Zanzibar Reproductive, Maternal, Newborn, Child and Adolescent Health Strategic Plan (2019-2023), launched in 2019
3. The HRH policy Brief: A call for a comprehensive approach to strengthen Human Resources for Health in Zanzibar, adopted from the detailed 2017 Situation analysis report on HRH in Zanzibar
4. The Fact Sheet on Mentorship: Improving maternal and child health outcomes in Zanzibar, developed in 2018.
5. The Fact Sheet on Task Shifting: Making the impossible possible, in 2018

It has been documented from studies in low and middle income countries (including in Zanzibar) that having evidence-based guidelines adapted to the local context have a potential to improve the quality of maternal and newborn care (Bishanga et al., 2018; Maaløe et al., 2019; Nababan et al., 2017). Accordingly, involvement of Afya Bora in establishing national strategies and guidelines gives an indication that Zanzibar will be able to continue with excellence in programming for RMNCAH and Nutrition beyond the life of the project. Nevertheless, such national documents should be translated into protocols and job aids that can be easily put into application by health care workers at service delivery sites. This is the programming area that was not as strong for the seven health facilities visited during the evaluation. Besides some job aids posted on walls in maternity wards, facilities had few guidelines and/or protocols for reference. Most available documents that were revealed were not readily available at working station, not comprehensive considering the range of services provided and/or not up to date based on the status of latest national policies/guidelines. Some studies have reported that low adherence to standards of care observed in LMICs could be attributed to lack of written care guidelines and/or job aids in health facilities, despite having such policies at national level (Kruk et al., 2018; Smith, Currie, Cannon, Armbruster, & Perri, 2014).

5 Conclusion, Lessons Learned and Recommendations

Conclusion

Afya Bora was a successful project that contributed to improved RMNCAH outcomes in Zanzibar including lower maternal and neonatal deaths.

At the strategic level, Afya Bora demonstrates the effects of joint programming if implemented well which has been problematic for most UN joint programmes. By working in similar facilities and using each agency's comparative advantages, together they were able to deliver a comprehensive package of services that has had profound effects on RMNCAH outcomes in Zanzibar. The agencies also demonstrated adaptive management with several changes to the project introduced in response to a changing context e.g. introduction of the mentorship programme, HRH information system, etc.

Significant achievements were made in building a mass of HRH with requisite skills and knowledge to deliver RMNCAH services in Zanzibar. Investment in long-term training was both necessary in the context of Zanzibar but demonstrated flexibility on the part of the funder. Such investments coupled with mentorship have resulted in an exponential increase in caesarean sections, for example. The effects will likely be felt beyond the project. By strengthening pre-service training as well, the project will likely improve the quality of midwives produced by the health colleges in Zanzibar. However, key challenges remain for the strengthening HRH in Zanzibar including task shifting, inadequate staffing, and low motivation due to poor working conditions. These are likely to undermine perpetuation of the positive effects of the project.

The CHV programme was one of the most successful components of Afya Bora with the project becoming synonymous with the CHV programme at the district level. CHVs were respected and regarded as a credible source of information on health by communities, demonstrating the effectiveness of capacity building, supervision and support. An impressive reach of 394,248 beneficiaries between September 2016 and September 2019 demonstrates how the project was able to take the CHV component to scale quickly and effectively based on flexible management and project implementers' motivation to succeed under very challenging timelines. The challenge maybe transferring an intensively managed programme to a relatively understaffed and under-resourced government. As the programme is taken up by the Revolutionary Government of Zanzibar, there is still a role for the UN agencies to support with lessons drawn from implementing the component under Afya Bora.

Further supporting the success of the project was an appropriately designed project that had a sound understanding of the challenges underpinning poor RMNCAH outcomes for Zanzibar. It addressed both demand and supply side factors in a holistic manner as demonstrated by how it was able to adequately address all elements of the theory of change for improving RMNCAH in Zanzibar. That said there remained some gaps. First, gender though recognised by project implementers as necessary and with some isolated interventions made (e.g. male champions), there was no systematic approach to: 1) analysing the gender entry points; 2) determining systematic interventions to be implemented across the project; and 3) identifying measurements of performance on gender responsiveness. Adolescents were another gap in the project design and implementation and required a systematic approach of addressing their SRH needs.

While the UN agencies through the project have played a critical role in facilitating the development of a number of policies and guidelines to sustain performance by HCWs and investments by MOHZ, the lack of a formal exit strategy shared understood with MOHZ and with key milestones will undermine continued investments in Afya Bora outputs. Concerns remain on preventive maintenance of equipments, use of the equipments, etc. in the absence of a decentralised Logistics Management Information System (LMIS) and sustainability of performance of HCWs given the context mentioned above.

Lessons Learned

1. **Lesson 1: Deployment of community health volunteers (CHVs) was considered by most stakeholders to be an effective strategy in improving healthy behavior in RMNCAH and Nutrition.**
2. **Lesson 2: Health care workers feel supported and have confidence to use their new skills when there is a continuous mentorship plan.** For instance, the introduction of two obstetricians, one in Unguja and another one in Pemba, was commended by HCWs who admitted being strengthening their skills.
3. **Lesson 3: Clear branding and communication on the project is necessary at all levels to maintain the project's visibility.** Some beneficiaries could not clearly attribute support received to Afya Bora due to lack of clear branding of the project. It was easier to identify attribution by individual partners implementing the project, which could introduce a confusion when a partner is involved in more than one projects. Future projects should consider having a standardized way to brand and present project's support among stakeholders for proper recognition.
4. **Lesson 4: Investment on medium and long term trainings by Afya Bora seemed to make impact in both coverage and quality of RMNCAH services**.
5. **Lesson 5: Ensuring all partners and stakeholders have a common understanding on all priority groups including approaches to reach them is critical to adequately translate the project design to implementation**. While the design of the project had adolescents and young people as a priority target group, this did not translate to implementation.
6. **Lesson 6: Lack of gender analysis at the onset of the project limits project managers to address influences of gender on project outcomes.** Therefore, incorporating gender analysis as an integral part of the project inception process enhances gender responsiveness of the project.
7. **Lesson 7: Incorporating SRH in RMNCAH projects enhances achievement of outcomes.** This should be buttressed by a strong male involvement. The project realised later in implementation that family planning was a critical in supporting RMNCAH and added later in the project.
8. **Lesson 8: Investments in HRH to be successful need to be supported increased staff levels, improved conditions of service and an efficient HRH information management system to ensure new skills and knowledge are put to use**.
9. **Lesson 9**: **Accompanying equipment provision with capacity building of staff ensures utilisation of the equipment.** There were instances where equipment remained in boxes or unused because staff did not have capacity to ensemble or use. MOHZ need to ensure distribution of equipments to health facilities includes support in assembling them and orienting staff so that the equipment is immediately and regularly in use.
10. **Lesson 10: Instituting a mentorship programme and strengthening supportive supervision by CHMTs ensures newly transferred skills and knowledge by trained health service providers are put into practice effectively.** The project implemented mentorship support for surgeons on caesarean sections which led to mentees building confidence in their ability and subsequently a substantial increase in caesarean sections. Supportive supervision was noted as key to ensure trained supervisors implement new knowledge and skills. Supportive supervision also provides trained staff an opportunity to seek guidance on skill and knowledge they struggle to put to practice.
11. **Lesson 11: An MNCAH programme premised on a strong gender analysis at design will enhance systematic mainstreaming of gender and with it deeper MNCAH outcomes.** No gender analysis was undertaken for the project and therefore there was no systematic plan to incorporate into

project activities. Although, during implementation, initiatives such as enhancing male involvement through CHV male champions were undertaken these were after thoughts and could have benefited from a systematic approach. There is therefore a need to enhance gender by undertaking gender analyses to identify entry points for a similar project to enhance its gender responsiveness.

12. **Lesson 12: An exit strategy, with targets and milestones, should be developed and a shared understanding of its implementation achieved to guarantee implementation of provisions to ensure sustainability.** The absence of an exit strategy that is owned by all stakeholders in Afya Bora led to an incoherent implementation of sustainability-oriented interventions.
13. **Lesson 13: Project implementation guiding documents and orientation of implementing partners enhances inclusion of all priority groups during project implementation and that their specific targets are being met.** In this regard, especially working with adolescents and young people, considered, as dynamic, adaptive management is critical.
14. **Lesson 14: To be effective, a uniform approach to addressing SRHR in a similar project is a requirement.** A future project should establish a systematic approach to address SRHR needs of young people. The approach used by Afya Bora was not uniform with key service providers HCWs and CHVs ill-equipped to provide SRHR services to young people.

Recommendations

The following recommendations are made from the evaluation. The recommendations have been prioritised according to short term and long term and level of priority. The recommendations, were drawn from findings by the evaluation team and presented to stakeholders (mainly: UNICEF, UNFPA, MOHZ and Save the Children) to provide inputs and feedback.

Priority Levels: 1= is a must implement; 2= implementable in stages; 3= implementable when resources permit.

Recommendation	Lead Responsible	Other parties	Immediate/ Medium/ Long term	Priority Level (1, 2 or 3)
Recommendation 1: Build a strong health information system to lay the foundation for evidence-based health sector planning. Use of the health information system for the project's M&E was commendable as it contributes to strengthening the system to data demand. However, quality of data at both facility and national level was not proportion to the investment made into improvement of services. The health information system is characterized by poor or missing documentation, clear system on data use for improvement and non-functional electronic databases, for example for HRH. These weaknesses should force a rethink of data sources for a future project but should spur a focus on strengthening the system to provide quality, reliable and complete data. The evaluation therefore recommends that a future project should have a component of strengthening the HMIS system by addressing bottlenecks in its operation including ensuring age (to measure impact on adolescents) and sex disaggregation of data.	MOHZ	UNFPA, UNICEF	Immediate	1
Recommendation 2: Establish a well-coordinated system for selection of health workers for short term training which enhances value for money. The system for selection of health workers for short term training needs to ensure that right staff are selected and trained. There is need for MOHZ technical departments to coordinate with both CHMT and facility managers in selection of CHWs for various trainings to ensure equity as well as effectiveness of trainings in improving quality of care.	MOHZ		Medium term	2
Recommendation 3: Maintain minimum standards of care by ensuring availability of national guidelines and protocols at health facility level. The evaluation found that in a majority of facilities the full complement of standard protocols and job aides were unavailable yet studies (including others in Zanzibar) have shown the importance of the presence of referral points in quality of service delivered to mothers and children. Structured on the job training including use of job aids will	MOHZ		Immediate	1

Recommendation	Lead Responsible	Other parties	Immediate/ Medium/ Long term	Priority Level (1, 2 or 3)
facilitate transfer and retention of skills among health care workers in supported facilities. Thus, the MOHZ needs to give attention to dissemination of national guidelines and/or protocols to service delivery points where care actually happens. Health care workers and facility staff should be well oriented and able to operationalize guidelines in their routine work.				
Recommendation 4: Strengthen the referral system to support provision of quality care at all levels. The evaluation found the referral system not functioning as it should, depriving mothers and children appropriate care. The referral system needs to be strengthened to support provision of quality care at all levels. Some components for consideration include: budget ambulance's fuel; proper documentation of referrals for both received and referred cases; and communication between referring and receiving health facility (counter-referral).	MOHZ	UNICEF, UNFPA	Long term	1
Recommendation 5: Put in place a system that incentivizes remote placement to achieve equity in quality of service delivery. Health care workers are calling for equity in incentives regardless of a station of work so that they are motivated to work anywhere in the islands. For instance, those working far from their homes should be considered for compensation on fare; allowances for uniform should be given to all HCWs in the country; etc. This would encourage staff retention in remote areas where staff have to spend more resources than their counterparts in other areas. It is recommended that the MOHZ should develop an incentive system to ensure equity in staff retention and in turn quality health service delivery.	MOHZ	UNICEF, UNFPA	Long term	2
Recommendation 6: Scale up of CHVs with the new strategy should build on investment and gains from Afya Bora. At the time of the evaluation, MOHZ was reconstituting CHVs. This has dangers of eroding capacity (skills, knowledge and relationships) created through Afya Bora and may pose a risk in regressing the gains. For instance, supervisors and CHVs under Afya	MOHZ	Current funders of the CHV programme, UNICEF, UNFPA	Immediate	1

Recommendation	Lead Responsible	Other parties	Immediate/ Medium/ Long term	Priority Level (1, 2 or 3)
Bora are an important resource to the new program based on their knowledge, competencies and trust from the community.				
Recommendation 7: Put in place preventive maintenance system to maintain equipment and buildings supported by Afya Bora. Districts had no operations and maintenance plan for equipments and buildings supported by the project. The project design and implementation did not put emphasis on this which was a weakness for sustaining the investments. The MOHZ and local governments should include a budget to maintain equipment and buildings that were supported by Afya Bora so that they continue being functional. Linked to this, a future similar project should put in place an exit strategy that includes development and implementation of maintenance plans.	MOHZ	UNICEF, UNFPA	Medium to long term	1
Recommendation 8: Streamline roles between MOHZ technical departments and CHMTs to ensure efficient coordination. With decentralization, coordination between technical departments at the MOHZ and CHMTs needs to be better streamlined on roles for efficient coordination. Senior officers at both LGAs and MOHZ are expected to guide and support their staff through the process of transition.	MOHZ		Immediate	1

Annexes

Annex 1: Terms of Reference

UNICEF TANZANIA COUNTRY OFFICE
Terms of Reference
Institutional Contract
Final Evaluation of Afya Bora ya Mama na Mtoto project (2015-2018)

1. Summary

Title	Final Evaluation of Afya Bora ya Mama na Mtoto project (2015-2018)
Purpose	To generate substantive evidence and lessons learned on the relevance, effectiveness, efficiency, sustainability, gender and equity focus of the Afya Bora ya Mama na Mtoto project
Location:	Zanzibar
Start Date:	01 February 2019
Duration:	Approximately 8 months
Supervisor:	Health Manager

2. Background information

Zanzibar has made considerable progress in child survival over the last decade. The 2015/2016 TDHS shows a reduction of under-five mortality from 73 per 1,000 live births in 2010 to 56 per 1,000 live births in 2015. Improvements have also been made in reducing malnutrition - a major underlying cause of child mortality. Stunting had declined from 30% in 2010 to 24% in 2015, and the number of children experiencing wasting has been almost reduced by half over the same period. However, critical maternal and newborn health indicators remain a significant concern with Maternal Mortality Ratio (MMR) record of 276 deaths per 100,000 live births in 2016 (MOH, 2016) – meaning that 94 mothers died from delivery or during immediate aftermaths in Zanzibar in 2016. The neonatal death rate has remained stagnant with only one point decline from 29 to 28 per 1000 live births between 2005 and 2015, with major causes of death being asphyxia, low birth weight, and infections.

Launched in 2015, the Afya Bora ya Mama na Mtoto ("Better health for mothers and children") project is designed to address maternal and child mortality and improve health and overall well-being for mothers and children in Zanzibar. The project targets 75,000 pregnant women, 130,000 mothers/caregivers of children 0-59 months, 260,000 children aged 0-59 months and 130,000 adolescents covering all areas of Zanzibar. The Government of Canada entrusted a total allocation of 15 million Canadian Dollars to UNICEF and UNFPA to implement the project with the support of various departments of the Ministry of Health and Save the Children International (SCI). The overall expected outcome of the project is the improved health and wellbeing of women and children in Zanzibar. It is in line with the Zanzibar Health Sector Strategic Plan (2013/14-2018/19), the Road Map to Accelerate the Reduction of Maternal, Newborn and Child Mortality in Zanzibar (2008-2015), the Zanzibar One RMNCAH Strategic Plan (2018-2022), UNDAP II and MKUZA III key expected results in the health sector and DFATD's development priority in Securing the Future of Children and Youth,

and its Bilateral Country Development Strategy 2014-2019. It is also expected to contribute the implementation of concluding observations on the combined third to fifth periodic Convention on the Rights of the Child's reports of the United Republic of Tanzania, particularly those related to health and health services. UNICEF and UNFPA contribute to reaching this objective by achieving two intermediate outcomes specified in the project. The Afya Bora project document specified the need for project evaluation at the end of the project implementation with an aim to generating evidence, lessons learned and document best practices, and analyze what did not work well to strengthen future anticipated programme design. The timing of the project evaluation was agreed with Global Affairs Canada (GAC).

Project overview

UNICEF and UNFPA contribute to the achievement of the Afya Bora ya Mama na Mtoto project's objectives by achieving two following intermediate outcomes:

1. Intermediate Outcome 1: A strengthened health system delivers more equitable and integrated health services, including improvement of the referral system.
    3.1. Immediate Outcome 1.1: Strengthened district health management systems to improve the quality of reproductive, maternal, newborn and child health (RMNCH) services in Zanzibar.
    3.2. Immediate Outcome 1.2: Strengthened health human resources (HRH) capacities to deliver high-quality RMNCH and nutrition services.

2. Intermediate Outcome 2: Increased coverage of quality emergency obstetric care, newborn and child health services, including high impact nutrition interventions.
- Immediate Outcome 2.1: Strategically placed district health facilities strengthened for the provision of quality new-born, child and 24/7 EmONC services, including emergency referral.
- Immediate Outcome 2.2: Strengthen community health systems to promote RMNCH care-seeking behavior and positive Health, WASH and Nutrition practices, including by young people.

The first year of the Project was mainly used for recruitment of implementing NGO, procurement of supplies and the start of the renovation of strategic health facilities. The second year of the Project was the completion of renovation and supply of equipment in 6 out of the 8 facilities strategically located to provide quality 24/7 basic emergency obstetric and newborn care for deprived and less served remote areas; Improved blood transfusion services – through the procurement of equipment and community mobilization for voluntary blood donation. The Zanzibar Blood Transfusion Services is now able to provide life-saving blood components meeting more than 80% of the total blood demand of the health system. To strengthen community health system 1,760 community health volunteers have been recruited and capacity build on family visits and provide information to pregnant women and caregivers of children under five years. Improving screening and referral system for severely malnourished children - the number of children under five years old with severe acute malnutrition (SAM) who were admitted for treatment almost doubled in one year, passing from 960 in 2015 to more than 1,800 in 2016, which represents 34% coverage out of an estimated caseload of 5,200 children with SAM in Zanzibar every year. This was mainly due to regular screening and referrals conducted at a community level by the network of CHVs. The project focused on the increased coordination of the reproductive, maternal, newborn, child and adolescent health (RMNCAH) and nutrition sector and improved integration of interventions of all stakeholders in Zanzibar. The third year of the Project Establishment was to strengthen a national Maternal Perinatal Deaths Surveillance and Response (MPDSR) system at central, district and facility levels for continuous quality improvement of maternal and newborn health care in Zanzibar. Overall, thanks to Afya Bora project, all 78 maternal deaths at health facilities (100%) and 461 out of 475 (more than 90%) early neonatal deaths were identified, reported and reviewed at a health facility and district

level. Deaths' review, which is part of MPDSR, has enabled maternal and new-born stakeholders to identify preventable deaths, their causes and consequently put in place resources for prevention of future deaths from similar causes. Successful completion and dissemination of the 2017 Zanzibar Human Resources for Health situation analysis, a critical assessment of the current human resources needs in the area of RMNCAH; this analysis has explored the staffing availability and gaps, the constraining factors on retention of RMNCAH workforce, updated database and provided the current state of the human health resources with particular focus on RMNCAH workforce for a logical and needs-oriented HRH planning and decision making. The joint assessment was conducted, and review of RMNCH and the development of Zanzibar One Reproductive, Maternal, Newborn, Child and Adolescent Reproductive Health Strategic Plan (2018 – 2022) completed through enhanced integration of interventions of all stakeholders in Zanzibar.

3. Purpose and objectives of the Evaluation

After three and half years of implementing, the final evalution of the Afya Bora ya Mama na Mtoto project is carried out with the primary purpose of generating substantive evidence and lessons learned on the relevance, effectiveness, efficiency, sustainability, gender and equity focus of the Afya Bora ya Mama na Mtoto project. The evaluation findings and recommendations will be used to strengthen future anticipated project design, to inform the nation-wide scaling up of the project, the end-term review of Zanzibar Health Sector Strategic Plan (2013/14-2018/19) and the 2020 mid-term review of Zanzibar One Reproductive, Maternal, Newborn, Child and Adolescent Reproductive Health Strategic Plan (2018-2022).for the 2020 mid-term review of Zanzibar One Reproductive, Maternal, Newborn, Child and Adolescent Reproductive Health Strategic Plan (2018-2022). Therefore, the primary audience of this evaluation includes the Zanzibar Ministry of Health, Zanzibar Ministry of Finance and Planning, UNICEF Tanzania Country Office and the GAC in Tanzania.

The specific objectives of the evaluation are to:

4. Determine the relevance, effectiveness, efficiency, sustainability, gender and equity focus of the Afya Bora ya Mama na Mtoto project;
5. Assess the integration of critical organizational principles and approaches, namely equity and gender in project planning, implementation, and monitoring.
6. Document good practice, lessons learned and provide actionable recommendations for improved future anticipated project design, advocacy for scaling up as well as for the improvement of MoH strategies, MNCAH and Reproductive Health Plan of Zanzibar.

4. Evaluation criteria and questions

The evaluation is expected cover the following criteria and questions:

1. RELEVANCE.

- To what extent are the project design, results and implementation strategies relevant to the national and local contexts, strategies, policies, and programs?

2. EFFECTIVENESS.

- To what extent have the project's objectives and intended results been achieved?
- What are the factors that facilitate or inhibit the achievement of the project's objectives and outcomes?
- Which project activities had more significance to contribute to increased demand, coverage and uptake of quality emergency obstetric care, newborn and child health services, including high impact nutrition interventions?

- To what extent has the project addressed accountability and ownership of implementing partners?
- How adequate have UNICEF's supports been to the project, including from the perspectives of different partners at national and sub-national levels?

3. EFFICIENCY:
   - To what extent have the project management and coordination been efficient?

4. EQUITY and GENDER:
   - To what extent have the project design and interventions taken into account the most vulnerable and hard to reach population?
   - To what extent have sex and age-disaggregated data been collected, monitored and analyzed to inform the project?

4. SUSTAINABILITY:
   3.1. What are the enabling as well as constraining factors that influence the sustainability of the project?
   3.2. What could or should be done differently in future replication and scaling up of the project?
   3.3. How will good practices generated from the project be bought in and sustained at both national and sub-national levels?
   3.4. What are the good practices and key conditions for national scaling up of the project?

The impact will not be assessed given the fact that it is too early to provide an accurate picture of the impacts (i.e., impacts will be understated when they had insufficient time to develop) and the baseline data has not been collected before the project interventions. The above-mentioned evaluation questions are a loose guide for the development of a proposal for bidding submission; they can be further refined by the selected evaluation team at inception phase, along with a detailed evaluation matrix outlining how each evaluation question will be answered. UNICEF being a rights-based organization, will ensure the evaluation will take gender, equity and human rights lenses throughout the process.

5. Scope of the evaluation

The evaluation will cover all components of the Afya Bora ya Mama na Mtoto project for the period from the start of the project in 2015 to December 2018. In terms of geographical areas, the evaluation will cover selected districts in Unguja and Pemba regions including national level referral hospital.

6. Methodology and technical approach

The evaluation will use mainly qualitative methods, including desk review of key documents (proposal, log frame, baseline studies, progress reports, expenditure reports, and relevant national policy and strategy documents) and primary data collection tools such as in-depth interviews with key informants, focus group discussion, and consultations with key stakeholders at the national and sub-national levels (including relevant partners, UNICEF, other relevant UN agencies and development partners). A human rights-based, participatory and inclusive approach, is highly expected. A full methodological proposal is expected as part of the Inception Report to be delivered by the selected evaluation team.

Data will be collected from selected districts in Unguja and Pemba regions and national level including national level referral hospital in Zanzibar. For collecting qualitative data, the interviewees

and focus group participants will be selected on the basis of gender and participatory perspectives. The sampling design will be further discussed prior to implementation of the evaluation.

Key informants that should be interviewed include the ministry of health officials, program managers, national referral hospital managers, district medical officers, UNFPA, WHO, health workers, NGOs involved and community health workers, mothers/caregivers and village executive officers.

The selected evaluation team is required to act with independent judgment, give a comprehensive and balanced presentation of the strengths and weaknesses of the programme being evaluated, and demonstrate consistent and dependable findings and recommendations.

The selected evaluation team is required to adhere to UNEG norms and standards for evaluations as well as UNICEF Procedure for Ethical Standards in Research, Evaluation and Data Collection and Analysis (effective from 1st April, 2015). For this purpose, it is suggested that the evaluator(s) will complete the Agora course on Ethics in Evidence Generation (https://agora.unicef.org/course/info.php?id=2173) before conducting data collection". The selected evaluation team will need to demonstrate awareness of the ethical considerations arising from the data collection, as well as appropriate procedures and planning for ethical evidence generation with children, including informed consent and confidentiality.

Once the evaluation methodology is agreed, it will have to be forwarded to an institutional ethical evaluation board for approval. The selected evaluation team will be responsible for obtaining the ethical approval and will submit the report from the evaluation to UNICEF before data collection.

7. Tasks, deliverables, and timeframe

The evaluation is scheduled from February to October 2019

Task	Deliverable	Time Frame
1. Conduct a desk review and consultation with key stakeholders	**Deliverable 1:** Inception Report (in English)	Feb-Mar 2019
2. Develop inception report including detailed evaluation methodology and tools, evaluation matrix, reconstructed underlying theory of change, work-plan, report outline in close consultation with UNICEF and key stakeholders		
3. Conduct data collection	**Deliverable 2:** 1st draft evaluation report (in English)	Apr-Jun 2019
4. Data Processing, Analysis and Report writing		
5. Prepare 1st draft evaluation report		
6. Consult with key stakeholders on the 1st draft evaluation report	**Deliverable 3:** Revised draft evaluation report (in English)	July – Aug 2019
7. Revise the draft evaluation report, taking into consideration of comments and feedbacks		
8. Validate the revised draft evaluation report with key stakeholders	**Deliverable 4:**	Sep - Oct 2019

9. Finalize and submit the evaluation report including abstract, executive summary, full report, Powerpoint presentation of key findings and recommendations, all annexes and data sets	Final evaluation report (in English) including abstract, executive summary, full report, Powerpoint presentation of key findings and recommendations, all annexes and data sets	

8. Management:

Direct supervisor of this consultancy is the Health Manager, Health section, UNICEF Tanzania.

In addition, management and governance arrangements for the evaluation will be established with a view to maximizing the credibility and hence utility of the evaluation.

The evaluation will be co-managed by the Health Manager, Health section and the Monitoring and Evaluation Specialist (Child Rights Monitoring, Research and Evaluation). The Monitoring and Evaluation Specialist will be responsible for the day-to-day technical management of the evaluation and the communication with the evaluation team while the Health Manager, with the support of the Health Specialist in Zanzibar office, will be responsible for the day-to-day administrative management of the evaluation as well as the coordination with key stakeholders, inter alia, including Ministry of Health in Zanzibar.

As co-managers for the evaluation, the role of the Health Manager and the Monitoring and Evaluation Specialist will be to oversee the evaluation from inception to product dissemination, including: recruiting and managing the evaluation team, serving as the interlocutor with relevant stakeholders, monitoring the budget and work plan, organizing field missions and desk search to support data collection, coordinating Reference Group meetings, and ensuring clear and consistent communications with key stakeholders. In managing the evaluation team, the Monitoring and Evaluation Specialist will focus on ensuring adherence to the ToRs and to established norms and standards for evaluation.

An Evaluation Reference Group will constitute the main consultation platform. The Group will serve in an advisory capacity, its key role being to help strengthen the evaluation's substantive grounding and its relevance to the Organization, and thereby increase its ultimate utility. Key roles and responsibilities of the Evaluation Reference Group are included in Annex 2).

The Evaluation Reference Group includes:

- Director of Department for Policy, Planning and Research, Ministry of Health (Zanzibar)
- Chief of Health section, UNICEF Tanzania
- Health Advisor, Global Affairs Canada
- Regional Health Advisor, UNICEF Eastern and Southern Africa
- Regional Evaluation Advisor, UNICEF Eastern and Southern Africa
- Chief, Zanzibar Field Office, UNICEF Tanzania
- Zanzibar Resident Programme Officer, UNFPA

Some stakeholders will be closely involved in the project evaluation. In gathering data and views from stakeholders, the selected evaluation team will ensure that it considers a cross-section of stakeholders with potentially diverse views to ensure the project evaluation findings are as impartial and representative as possible.

9. Qualifications and experience required

The evaluation will be conducted by an institution. The institution must have a good track record and extensive experience in planning and conducting evaluations, particularly in the field of health and nutrition. The composition of the proposed evaluation should be gender balanced and include a team leader and team member(s) with the following qualifications and experience:

Team Leader's qualification and experience:
• Must hold at least a Master's Degree in one or more of the disciplines relevant to the following areas: evaluation, development studies, public health, or social sciences
• At least 7 years of recognized experience in conducting or managing/leading evaluations or review of development programmes, and experience as team leader of evaluation team and as main writer of evaluation reports
• Expertise on quantitative and qualitative evaluation/research methods
• Excellent knowledge and understanding of theories of change, logical/result frameworks, monitoring and evaluation systems and practice;
• Excellent skills and experience in facilitating key informant interviews and focused groups discussions with various groups of stakeholders;
• Familiarity with health and nutrition areas.
• Familiarity with the social and human rights-based approach, equity and gender issues
• Excellent analysis skills in writing evaluation reports with constructive and practical recommendations.
• Good audience-oriented communication, teamwork and presentation skills.
• Language: Fluency in written and spoken English. Knowledge of and Kiswahili will be an asset.

Team Member(s)'s qualifications and experience:
• Must hold at least a Master's Degree in one or more of the disciplines relevant to the following areas: evaluation, development studies, public health, or social sciences;
• At least five years of experience in conducting research, evaluations or review of development programmes, including specific experience in evaluating nutrition, health or similar programme/services.
• Excellent skills and experience in facilitating key informant interviews and focused groups discussions with various groups of stakeholders;
• Familiarity with health and nutrition areas.
• Familiarity with the social and human rights-based approach, equity and gender issues
• Excellent analytical and report writing skills
• Good audience-oriented communication, teamwork and presentation skills.
• Fluency in written and spoken English.
• Fluency in spoken and written Kiswahili will be an asset.

Any changes of Team Leader and/or Team Member during the consultancy should be approved by UNICEF.

Every effort has to be made to ensure team leader, and members are not in a position of conflict of interest. Consequently, individuals who have been directly involved in the implementation of the programme cannot serve as members of the evaluation team. Any other potential conflicts of interest will need to be declared by members of a team at the point of application.

11. Payment schedule

The payment schedule will be as follows:

- 20% of fees and 100% flight tickets, in-country travel cost, and DSA after approval of the inception report including detailed evaluation methodology and tools, evaluation matrix, work-plan, report outline
- 20% of fees after submission of the 1st draft evaluation report
- 20% of fees after submission of the revised draft evaluation report
- 40% of fees after submission of the final evaluation report including abstract, executive summary, full report, Powerpoint presentation of key findings and recommendations, all annexes and data sets.

12. Assessment/selection process and methods

Interested institutions are invited to submit a technical proposal and financial proposal to carry out the evaluation. The contracted institution is also required to provide relevant samples of previous work. The institution will be selected based on the quality of the technical proposal and financial proposal. The weight allocated between the two will be 70/30 – 70 points for technical proposal and 30 points for the financial proposal.

Only those technical proposals that score 50 points or more out of 70 will be shortlisted for the financial proposal assessment stage.

The following criteria and relative points will be used to assess the technical proposal:

Technical Criteria	Technical Sub-criteria	Maximum Points
Overall Response	Completeness of response	5
	Overall concord between RFP requirements and proposal	5
Maximum Points for overall response		**10**
Institution and Key Personnel	The institution must have a good track record and extensive experience in planning and conducting evaluations, particularly in the field of health and nutrition.	10
	Key personnel: 3.1. Proposed team structure 3.2. Relevant experience and qualifications of team-leader/team-member(s)	20
Maximum Points for Institution and Key Personnel		**30**
Proposed Methodology and Approach	Relevance and rigor of the technical approach/ methodology	20
	Monitoring and quality assurance process	5
	Innovation approach	5
Maximum Points for Proposed Methodology and Approach		**30**
TOTAL Maximum		**70**

13. Administrative issues

UNICEF Tanzania is planning to sign an institutional contract based on the following conditions:
- No work may commence unless both UNICEF Tanzania and the institution sign the contract.

• The institution is responsible for making arrangements for office premises, transport, and equipment (laptop and other ICT equipment).
• Should the institution require specific assistance/materials from the UNICEF Tanzania office and national partners, he/she should request at least ten days before the start of the mission.
• UNICEF Tanzania and government counterparts will facilitate access to specific data/institution/personnel/location for this exercise.
• The institution will be in regular communication with UNICEF Tanzania designated focal person for the assignment, the Health manager.

UNICEF Tanzania will provide venue and facilities for meetings with the Evaluation Reference Group and other key stakeholders.

ANNEX 1: KEY Documents recommended to be reviewed

- Afya Bora ya Mama na Mtoto project (2015-2018) (2015).
- Zanzibar One Reproductive Maternal Newborn Child Health Strategic Plan (Draft)(2018-2022
- Zanzibar Health Sector Plan III
- Zanzibar Mid-term Review report (2017)
- Project Cooperation Agreement with Save the Children Yr # 3 (2018/2019)
- MKUZA III
- Zanzibar Nutrition Strategy
- Assessment of New-born care health care delivery (UNICEF, 2017)
- Emergency Obstetric Care Assessment (UNFPA, 2018)
- Human Resource for Health Assessment (UNFPA, 2017)

Annex 2: Key roles and responsibilities in the evaluation process

There will be 3 main actors involved in the implementation of this evaluation:

1. Health Manager of the Health Section and the Monitoring and Evaluation Specialist (Child Right Monitoring, Research and Evaluation) of Social Policy Section as **co-managers** of the evaluation will have the following roles and responsibilities (based on UNICEF Tanzania's Standard Operating Procedure on Research, Studies and Evaluation Management):
    - Lead the management of the evaluation process throughout the 3 main phases of an evaluation (design, implementation, dissemination and use)
    - Convene and provide coordination support to the evaluation reference group
    - Lead the finalization of the evaluation ToR
    - Coordinate the selection and recruitment of the evaluation team by making sure the lead agency undertakes the necessary procurement processes and contractual arrangements required to hire the evaluation team
    - Provide the evaluators with administrative support and required data
    - Ensure the evaluation products meet quality standards
    - Provide clear specific advice and support to the evaluation team throughout the whole evaluation process
    - Connect the evaluation team with the wider programme unit, senior management and key evaluation stakeholders, and ensure a fully inclusive and transparent approach to the evaluation
    - Review the inception report and the draft evaluation report(s);
    - Ensure that adequate funding and human resources are allocated for the evaluation
    - Take responsibility for disseminating and learning across evaluations on the various programme areas
    - Safeguard the independence of the exercise, including the selection of the evaluation team

- Regularly update Senior Management on the progress of the Evaluation.

2. **The Evaluation Reference Group** comprising the representatives of the major stakeholders, will have the following roles and responsibilities. The Reference Group will provide advice and challenge to the evaluation. Internal stakeholders and external experts will be used to guide and challenge the evaluation process. The Evaluation Reference Group will ensure that the evaluation draws on current good practices. Members will be asked to devote their time and expertise. The Evaluation Reference Group will mostly operate by phone and email exchange.

- Review the inception as well as draft evaluation report and ensure final draft meets quality standards and requirements of TORs
- Facilitating the participation of those involved in the evaluation design
- Identifying information needs, defining objectives and delimiting the scope of the evaluation.
- Providing input and participating in finalizing the evaluation Terms of Reference
- Facilitating the evaluation team's access to all information and documentation relevant to the intervention, as well as to key actors and informants who should participate in interviews, focus groups or other information-gathering methods
- Oversee progress and conduct of the evaluation the quality of the process and the products
- Provide advice on the quality the evaluation process as well as on the evaluation products (comments and suggestions on the adapted TOR, draft reports, final report of the evaluation) and options for improvement.
- Support disseminating the results of the evaluation

3. The evaluation team will conduct the evaluation by:

Fulfilling the contractual arrangements in line with the TOR, UNEG/UNICEF norms and standards and ethical guidelines; this includes developing an evaluation matrix as part of the inception report, drafting reports, and briefing the commissioner and stakeholders on the progress and key findings and recommendations, as needed

ANNEX 3. Indicative content of evaluation inception report

Main body of the report:

- Evaluation background
- Revised / updated theory of change and log frame of the evaluated programme / intervention
- Evaluation purpose and specific objectives
- Scope of the evaluation (timeframe, funding, geographical areas, population etc.)
- Description of the inception phase
- Summary of the outcomes of / findings from the meetings, data collection & analysis activities, and research carried out during the inception period
- Comments, interpretation, or adjustments on the ToR
- Evaluation criteria and final evaluation questions (including knowledge gaps identified and recommendations drawn from previous evaluations & studies)
- Hypotheses to be tested
- Consistency with or any change from the initial ToR
- Conceptual framework - notably: How the evaluation will address issues of complexity
- Evaluation design and overall methodology
- Data to be collected
- Data source (documents to be reviewed, stakeholders to be consulted through interviews, FGD, surveys etc.) including how key information will be triangulated
- Data collection methods: stakeholder survey, field visits and observation plan, document review and M&E advisory work etc. use of smartphones etc.
- Identification of potential bias (e.g. from respondents) and how they will be managed

- Sample and sampling method
- Description of data collection instruments (actual tools in annex)
- Enumerators' training and pilot testing of survey tools (if applicable)
- Enumerators' supervision & support
- Other methods used for quality assurance of collected data
- Data analysis methods (how data will be coded, displayed, processed, aggregated, synthetized, compared use of quantitative and qualitative data analysis methods, how to assess UNICEF's contribution to results e.g. causal contribution analysis, rival hypothesis etc.) taking into account the need to triangulate key information, judgmental statements or findings
- Any methodological and organizational limitations that need to be resolved prior to starting data collection or acknowledged throughout the evaluation process (other than triangulation and bias), or any risk and how they will be mitigated
- How equity and gender will be taken into account
- Identification of anticipated or actual ethical issues throughout the evaluation project as well as the measures and methods adopted to mitigate against these issues (methods or practices to ensure the avoidance or minimization of harm and stress to participants; security matters and protection protocols utilized - both for enumerators and people interviewed; getting an informed consent /verbal assent from participants; protection of privacy of participants; confidentiality and anonymity of data collected; absence of benefit or compensation offered to interviewees; training of enumerators in these issues and on enumeration/communication skills; official ethical review and registration at clinicaltrials.gov if appropriate).
- Work plan with description of deliverables and time-line, including provision of time for UNICEF, the evaluation steering committee, reference group or other stakeholders to provide feedback at each stage; and including final workshop for formulating or finalizing recommendations
- Logistics and support needed from UNICEF or other partners
- Evaluation communication & dissemination plan by category of primary and secondary audience, to ensure evaluation uptake and use beyond the commissioning office
- Final report template or outline

In annex:

- Full evaluation matrix linking evaluation criteria to questions, to hypothesis, to data to be collected, to data source, to data collection methods and sampling (and possibly to criteria or standards that will be used by the evaluation team to make a judgement on whether or not UNICEF as performed well in each particular evaluation question)
- Data collection tool: detailed and comprehensive enough for collecting all data needed and answering all evaluation questions
- Enumerators' interview/survey guide (if applicable)

ANNEX 4. STRUCTURE of the draft and final evaluation report

The report Structure is required to be adhered to the UNICEF-Adapted UNEG Evaluation Reports Standards

https://www.unicef.org/evaluation/files/UNICEF_adapated_reporting_standards_updated_June_2017_FINAL.pdf

ANNEX 5. Monitoring and Evaluation Matrix of the Afya Bora ya Mama na Mtoto project

NUMBER	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMULATIVE PROGRESS at 30 April 2018	TARGET (2018)	PROGRESS ASSESSMENT	MEANS OF VERIFICATION	
							DATA SOURCES	DATA COLLECTION METHODS
ULTIMATE OUTCOME								
10000	Improved Health and Wellbeing of Women and Children in Zanzibar	➢ Maternal mortality ratio ➢ Under five mortality rate reduced ➢ Stunting prevalence among children under five years reduced	➢ 310/ 100,000 (2013) ➢ 73/1,000 (2010) ➢ 24.4% (2014)	➢ 157/ 100,000 (MOH 2017) ➢ 56/1,000 (TDHS 2015) ➢ 23.5 (TDHS 2015)	➢ 94/ 100,000 ➢ 24/1,000 ➢ 21%	In progress	➢ MOH, ➢ TDHS, ➢ TNNS	➢ Routine HMIS ➢ Survey ➢ Survey
INTERMEDIATE OUTCOMES								
11000	Strengthened health system to deliver equitable and integrated health services, including improvement of the referral system	Proportion of facilities with star rating of 3 and above	0% (2014)	➢ 66 out of 165 facilities assessed (40%)	80%	In progress. Quality improvement plans prepared for all assessed facilities.	HSRS	Accreditation Reports
12000	Increased coverage of quality emergency obstetric care, new-born and child health services, including high impact nutrition interventions	Proportion of deliveries at health facilities	56% (2013)	62.4%	80%	Delayed.	HMIS (Health bulletin)	Annual Health Bulletin
		Number of children (0-59 months) with severe acute malnutrition treated according to guidelines per year	1,250	3,417	5,200	On track. This represents 67% coverage of estimated SAM caseload in Zanzibar	MOH	Routine DHIS2
IMMEDIATE OUTCOMES								
11100	Strengthened district health management systems to improve the quality of RMNCH services in all districts in Zanzibar	Proportion of districts timely submitting quarterly progress reports	0 (2014)	7	10	On track	ZHMTs	Quarterly progressive report

NUMBER	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMULATIVE PROGRESS at 30 April 2018	TARGET (2018)	PROGRESS ASSESSMENT	MEANS OF VERIFICATION	
							DATA SOURCES	DATA COLLECTION METHODS
11200	Strengthened HR capacity to deliver high quality RMNCH and nutrition services	Proportion of health facilities receiving 4 integrated MNCH supportive supervision visits every year	60% (2013)	85%	100%	On track.	IRCHS	Monitoring reports
12100	Strategically placed district health facilities strengthened for provision of quality new-born, child and 24/7 EmONC services including emergency referral	Number of health facilities with fully functioning CEmONC services	4 (2014)	7	6	Achieved. Quality and continuity of services to be improved.	HMIS	Routine HMIS data
		Number of health facilities with fully functioning BEmONC services	1 (2014)	7	8	On track.	HMIS	Routine HMIS data
12200	Strengthen community health systems to promote RMNCH care seeking behaviour and positive health, hygiene and nutrition practices, including by young people	Proportion of women attending all 4 ANC visits	48.9% (2010)	52.9%	60%	On track.	TDHS	Survey
		Proportion of women and new-born attending at least 1 PNC visit within the first 2 days after delivery	32.4% (2010)	40.2%	60%	On track.	TDHS	Survey
		Percentage of household that have soap and who report having used soap for hand washing at least at two critical times during past 24 hours	13.2% (2014)	N/A	30%	TNNS 2018 results will be available in December 2018. TNNS was postponed from 2017 to 2018.	TNNS	Survey
		Proportion of infants 0-5 months of age who are fed exclusively with breast milk	20% (2014)	N/A	40%	TNNS 2018 results will be available in December 2018.	TNNS	Survey
		Proportion of children aged 6 to 23 months receiving a minimum acceptable diet	8% (2014)	N/A	20%	TNNS 2018 results will be available in December 2018.	TNNS	Survey

NUMBER	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMULATIVE PROGRESS at 30 April 2018	TARGET (2018)	PROGRESS ASSESSMENT	MEANS OF VERIFICATION	
							DATA SOURCES	DATA COLLECTION METHODS
OUTPUTS								
11110	Improved annual planning and monitoring for RMNCH in Zanzibar	Proportion of districts which have developed satisfactory CDHPs that incorporate RMNCAH	0	100% (11 of 11 Districts)	100% (11 of 11 Districts)	Achieved. Quality improvement support is being provided.	Districts annual Plan	District Planning Meeting
11120	Improved performance and accountability of RMNCH services in Zanzibar	Proportion of districts and zones conducting regular maternal and perinatal death review meetings.	0 (2014)	a) 100% zones (2) b) 100% districts (11/11)	c) 100% zones (2) d) 70% districts (8/11)	Achieved. Regular reviews done after maternal and / or perinatal deaths.	IRCH	Quarterly MPDSR reports
11130	Strengthened RMNCH supply management system	Proportion of facilities without stock- out of essential medical supplies throughout the year	0% (2014)	85%	50%	On track.	IRCH/ CMS (Lifesaving commodities reports)	Quarterly report
11210	Existing staff development and retention policies reviewed and operationalised	Percentage of Health Care Professionals retained	TBD in baseline[27]	NA	At least 98%	HRIS presently not functioning nor updated.	Baseline staff attrition assessment & HRIS and training report	HR Bulletin (Report)
11220	Innovative approaches to staff development established and implemented	Number of new learning approaches integrated in the training programme	0	1	3	On Track. The 3 innovative learning approaches include: Task shifting; Mentorship; Use of ICT	Annual Joint Health Sector Review	CHS report
		Number of Innovations implemented	0	1	3			

[27] With the current HR management system the MOH doesn't have solid data on numbers of staff who have been retained (and for how long) after training.

NUMBER	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMULATIVE PROGRESS at 30 April 2018	TARGET (2018)	PROGRESS ASSESSMENT	MEANS OF VERIFICATION	
							DATA SOURCES	DATA COLLECTION METHODS
11230	Increased availability of high and mid-level skilled health workers for RMNCH service provision	Number of skilled health care workers met by 50% of established need.	TBD[28]	N/A	75%	HRIS system not functioning with outdated data.	HRIS	Training report & Deployment committee meeting report
12110	Improved capacity of selected facilities to provide quality new-born, child and EmONC services	Proportion of health facilities with at least two health providers who have received training on distance learning IMCI and Essential New-born Care	68%	85%	80%	Achieved.	(2016 IMCI report)	Supervision report and annual report (Training data base IRCH)
		Proportion of health facilities conducting maternal and perinatal death reviews	2.4%	100%	100%	Achieved. Regular reviews done after maternal and / or perinatal deaths.	(HMIS 2013)	HMIS report
12120	Improved infrastructure for delivery of 24/7 EmONC services in selected health facilities, including emergency referral	Caesarean Sections as a proportion of all births	4% (2013)	8.1%	5%	Within international standards for private 8.4 % and below international standards for public 1.6%	(HMIS)	HMIS report
		Proportion of all deliveries in basic and comprehensive EmONC Facilities	26% (2013)	30%	35%	On track.	(HMIS)	HMIS report

[28] See note n. 5.

NUMBER	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMULATIVE PROGRESS at 30 April 2018	TARGET (2018)	PROGRESS ASSESSMENT	MEANS OF VERIFICATION	
							DATA SOURCES	DATA COLLECTION METHODS
12130	Increased accessibility and availability of safe blood and components	Blood Bank freezer and refrigerator functional	1 Blood Bank freezer and refrigerator functional (2014)	2	2 Blood Bank freezers and refrigerators functional	Achieved.	ZNBTS	Annual routine data
		Number of safe blood units collected and distributed to health facilities	9,500 (2013/2014)	11,500	10,000	Achieved.	ZNBTS	Annual routine data
		Percentage of blood units processed into components	48% (2013/2014)	76%	80%	On track.	ZNBTS	Annual routine data
12140	Strengthened youth friendly SRH/FP service provision in selected districts	Number of youths utilized SRH/FP services	1,355 (2014)	4,539	10,000	Delayed. More efforts will be put on this.	RCH /HMIS	Quarter progress report
12210	Increased proportion of health facilities with at least one health worker trained to provide promotional RMNCH, WASH and Nutrition services	Proportion of health facilities with at least one health worker trained to provide promotional RMNCH, WASH and Nutrition services	0 (2014)	100%	80%	Achieved. A total of 556 health facility workers trained.	Training registers and reports	Programme monitoring and supervision
12220	Increased proportion of Shehias with at least one community health worker trained to provide screening and referral for malnutrition and promote RMNCH care seeking behaviour	Proportion of Shehias with at least one community health worker trained to provide promotional RMNCH, WASH and Nutrition services, provide screening and referral for malnutrition and promote RMNCH care seeking behaviour	0 (2014)	80%	80%	Achieved. 1,760 CHVs from 10 out 11 districts and 332 out of 387 Shehias (80%) were trained.	Training registers and reports	Programme monitoring and supervision

NUMBER	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMULATIVE PROGRESS at 30 April 2018	TARGET (2018)	PROGRESS ASSESSMENT	MEANS OF VERIFICATION	
							DATA SOURCES	DATA COLLECTION METHODS
12230	Increased number of pregnant women, caregivers of children under 5 years old and adolescents participating in promotional RMNCH, WASH and nutrition services	Number of pregnant women, caregivers of children under 5 years old and adolescents participating in promotional RMNCH, WASH and nutrition services per year	0 (2014)	79,525 caregivers; 21,483 pregnant women	> 78,000 caregivers of children under 5 45,000 pregnant women	Achieved for caregivers. Delayed for pregnant women. By end of the project, 75% of targeted pregnant women will be reached.	CHVs reports	Meetings among CHVs and supervisors, PHCUs and Shehias
12240	Increased coverage of promotional RMNCH, WASH and nutrition programs delivered through medias and schools	Number of persons reached with radio spots on RMNCH, WASH and nutrition messages per year	0 (2014)	18,600	400,000 persons	Delayed.	HPU	Media coverage surveys
		Number of students reached by teachers with RMNCH, WASH and nutrition messages per year	0 (2014)	18, 541 students	5,000 students	Achieved.	Teachers reports	Monitoring
12250	Improved coordination, monitoring and supervision of community health activities	Proportion of Shehias Health Custodian Committees holding at least two meetings with community health workers activities per year	0 (2014)	100%	80%	Achieved.	Progress reports	Monitoring
		Number of six-monthly monitoring/ reviewing meetings at Zonal level organized every year	0 (2014)	2	2 Zonal meetings	Achieved. Coordination of Afya Bora project was integrated into existing national health coordination platforms.	Progress reports	Monitoring

Annex 2: Evaluation Framework

Evaluation Criteria	Key Questions	Indicators	Methods	Data Sources
Relevance	To what extent are the project design, results and implementation strategies relevant to the national and local context, strategies, policies and programmes?	1. Alignment to national priorities (policies and strategies)	Document Review KIIs	MOHZ officials Local Government UNICEF, UNFPA Zanzibar Health Sector Strategic Plan (2013/14– 2018/19), Road Map to Accelerate Reduction in Maternal, New-born and Child Mortality in Zanzibar (2015-2018), Zanzibar One RMNCAH Strategic Plan (2018-2022), UNDAP II and MKUZA III
		2. Alignment to UNICEF global priorities including the five areas for RMNCAH and UNFPA global priorities	Document Review KIIs	UNICEF, UNFPA Project Design document UNICEF's Global Strategy for Health (2016-2030)
		3. Alignment to Government of Canada global priorities	Document Review KIIs	UNICEF, UNFPA, Embassy of Canada DFTAD Securing Children and Youth Muskoka Initiative
		4. Flexibility of design to accommodate emerging issues e.g. decentralisation, new policies, new issues, SRH	Document Review KIIs	MOHZ officials UNICEF, UNFPA, Save the Children Annual Reports
		5. Validity of assumptions for the Theory of Change	Document Review KIIs FGDs Case Studies	Annual Reports MOHZ officials UNICEF, UNFPA, Save the Children Health Workers in facilities Community Health Volunteers Pregnant women and those with children under 5 years

Evaluation Criteria	Key Questions	Indicators	Methods	Data Sources
		6. Target groups in relation to equity and drivers of maternal, neonatal and child mortality	Document Review Secondary data HMIS KIIs FGDs Case Studies	Project design document Annual Reports DHIS2 MOHZ officials UNICEF, UNFPA, Save the Children
Equity and gender focus	To what extent have the project design and interventions taken into account the most vulnerable and hard to reach populations?	1. Criteria for identification of project areas: a) Selection of facilities b) Selection of areas for CHVs	Documentary review KIIs	Project design document Annual reports MOHZ officials UNICEF, UNFPA, Save the Children
		2. Project investments: a) Financial resource allocation vis a vis depth of challenge	Documentary review Secondary data analysis KII	DHIS2 Project Financial reports and budgets Activity reports and budgets MOHZ officials UNICEF, UNFPA, Save the Children
		3. Coverage and appropriateness/adequacy of support for groups left behind: a) Adolescents b) Hard to reach areas c) Specific minorities	Document Review Secondary data HMIS KIIs FGDs Case Studies	Annual Reports MOHZ officials UNICEF, UNFPA, Save the Children Health Workers in facilities Community Health Volunteers Pregnant women and those with children under 5 years Adolescent girls and young women Men
	To what extent have sex and disaggregated data been collected, monitored and	1. Extent of use of sex disaggregated data	Documentary review KII	Annual Reports MOHZ officials UNICEF, UNFPA, Save the Children

Evaluation Criteria	Key Questions	Indicators	Methods	Data Sources
	analysed to inform the project?	2. Success and failures in approaches to engage men in RMNCAH	Documentary Review KII FGDs Case studies	Annual Reports MOHZ officials UNICEF, UNFPA, Save the Children Men
		3. Extent gender analysis was a premise for investments under Afya Bora including (renovations, training, community mobilisation etc)	Documentary review KII	Project design document Annual Reports MOHZ officials UNICEF, UNFPA, Save the Children
Effectiveness	To what extent have the project's objectives and intended results been achieved?	1. Performance of log frame indicators	Documentary review Secondary data analysis	Annual Reports DHIS2
	What are the factors that facilitate or inhibit the achievement of the project's objectives and outcomes?	2. Key drivers and barriers of performance in Afya Bora: a) Project design including capacity development approach (transformative vis a vis functional) b) Project management c) Implementer motivation	Document Review KIIs FGDs Case Studies	Project Document Annual Reports MOHZ officials, Health Worker Training Institutions Local Government UNICEF, UNFPA, Save the Children Health Workers in facilities Trained Health workers CHMT members Men Community Health Volunteers Pregnant women and those with children under 5 years
	Which project activities had more significance to contribute to increased demand, coverage and	1. Extent of: a) service referral by CHVs (RMNCAH, Nutrition etc)	Document Review Secondary data analysis	Project Document Annual Reports MOHZ officials, Health Worker Training Institutions

Evaluation Criteria	Key Questions	Indicators	Methods	Data Sources
	uptake of quality emergency obstetric care, new-born and child health services, including high impact nutrition interventions?	b) RMNCAH services provided at facilities	KIIs and FGDs	Local Government UNICEF, UNFPA, Save the Children Health Workers in facilities Trained Health workers CHMT members Community Health Volunteers Pregnant women and those with children under 5 years
		2. Community perceptions on the quality of health care provided at health facilities	FGDs Case studies	Pregnant women and those with children under 5 years Men Adolescent girls and young women
		3. Contribution of each project component to desired results as well as combination of interventions	Document Review Secondary data analysis KIIs and FGDs	Project Document Annual Reports MOHZ officials, Health Worker Training Institutions Local Government UNICEF, UNFPA, Save the Children Health Workers in facilities Trained Health workers CHMT members Men Community Health Volunteers Pregnant women and those with children under 5 years
	To what extent has the project addressed accountability and ownership of implementing partners?	1. Mechanism for performance measurement and its effectiveness	Document Review KIIs FGDs	Project Document Annual Reports MOHZ officials, Health Worker Training Institutions Local Government UNICEF, UNFPA, Save the Children

Evaluation Criteria	Key Questions	Indicators	Methods	Data Sources
				Health Workers in facilities Trained Health workers CHMT members Men Community Health Volunteers Pregnant women and those with children under 5 years
		2. Measures to ensure ownership including effectiveness - through demonstration of ownership	Document Review KIIs FGDs	Annual Reports MOHZ officials, Health Worker Training Institutions Local Government UNICEF, UNFPA, Save the Children Health Workers in facilities CHMT members Community Health Volunteers
	How adequate have UNICEF's support been to the project, including from the perspectives of different partners at national and subnational levels?	1. Adequacy and quality of management, and technical support from UNICEF	Document Review KIIs	
		2. Perceptions of stakeholders on support from UNICEF	Document Review KIIs/FGDs	Annual Reports MOHZ officials, Health Worker Training Institutions UNFPA, Save the Children
Efficiency	To what extent have the project management and coordination been efficient?	1. Level of functionality and effectiveness of national and subnational coordination platforms.	Document Review KIIs FGDs	Project Document Annual Reports MOHZ officials, Health Worker Training Institutions Local Government UNICEF, UNFPA, Save the Children

Evaluation Criteria	Key Questions	Indicators	Methods	Data Sources
				CHMT members Community Health Volunteers
		2. Was the staffing on the project commensurate with the scale and objectives?	Document Review KIIs	Project Document Annual Reports MOHZ officials, Health Worker Training Institutions Local Government UNICEF, UNFPA, Save the Children CHMT members Community Health Volunteers
		3. Platforms that exist for lessons sharing between partners and the benefits accruing.	Document Review KIIs FGDs	Project Document Annual Reports MOHZ officials, Health Worker Training Institutions UNICEF, UNFPA, Save the Children
		4. Monitoring systems put in place, their adequacy to provide information required for project management and how information from the monitoring system was used for project steering at all levels.	Document Review KIIs FGDs	Project Document Annual Reports MOHZ officials, Health Worker Training Institutions UNICEF, UNFPA, Save the Children
		5. Key drivers and constraints to coherence and coordination.	Document Review KIIs FGDs	Project Document Annual Reports MOHZ officials, Health Worker Training Institutions UNICEF, UNFPA, Save the Children
Sustainability	What are the enabling as well as constraining factors	1. What components will be sustained in the:	Document Review	Annual Reports

Evaluation Criteria	Key Questions	Indicators	Methods	Data Sources
	that influence the sustainability of the project?	a) Short b) Medium c) Long term	KIIs FGDs	MOHZ officials, Health Worker Training Institutions Local Government UNICEF, UNFPA, Save the Children Health Workers in facilities CHMT members Community Health Volunteers
		2. Individual, organisational and institutional factors supporting or constraining sustainability	Document Review KIIs FGDs	Annual Reports MOHZ officials, Health Worker Training Institutions Local Government UNICEF, UNFPA, Save the Children Health Workers in facilities CHMT members Community Health Volunteers
	How will good practices generated from the project be brought in and sustained at both national and sub-national levels?	3. What is required to support them: a) Key assumptions b) Provisions being put in place or in planning to support sustainability	Document Review KIIs FGDs	Project Document Annual Reports MOHZ officials, Health Worker Training Institutions Local Government UNICEF, UNFPA, Save the Children Health Workers in facilities Trained Health workers CHMT members Men Community Health Volunteers Pregnant women and those with children under 5 years
	What are the good practices and key conditions for	4. Initiatives that can be scaled up: a) What makes the initiative different?	Document Review	Project Document Annual Reports

Evaluation Criteria	Key Questions	Indicators	Methods	Data Sources
	national scaling up of the project? What could or should be done differently in future replication and scaling up of the project?	b) What is required to transform them to a national programme? c) What supports performance of the initiative? d) What could potentially undermine it?	KIIs FGDs	MOHZ officials, Health Worker Training Institutions Local Government UNICEF, UNFPA, Save the Children Health Workers in facilities Trained Health workers CHMT members Men Community Health Volunteers Pregnant women and those with children under 5 years

Annex 3: List of Documents Reviewed

Project Reports

UNICEF and UNFPA (2016) MPTF Office Generic Annual Programme Narrative Progress Report Reporting Period: 1 April 2015 – 30 April 2016. Report prepared for the Canadian Government

UNICEF and UNFPA (2017) MPTF Office Generic Annual Programme Narrative Progress Report Reporting Period: 1 April 2016 – 30 April 2017. Report prepared for the Canadian Government

UNICEF and UNFPA (2018) MPTF Office Generic Annual Programme Narrative Progress Report Reporting Period: 1 April 2017 – 30 April 2018 Report prepared for the Canadian Government

UNICEF and UNFPA (2019) MPTF Office Generic Annual Programme Narrative Progress Report Reporting Period: 1 May 2018 – 30 April 2019. Report prepared for the Canadian Government

UNICEF and UNFPA (2020) End of Project Report (1 April 2015 – 31 October 2019) Afya Bora ya Mama na Mtoto Project (2015-2019). Report prepared for the Canadian Government

National Documents

Revolutionary Government of Zanzibar (2017) Zanzibar Strategy for Growth and Reduction of Poverty (ZSGRPIII/Mkuza III).

Ministry of Health in Zanzibar (2019) Zanzibar Multisectoral Nutrition Action Plan (ZMNAP) 2019/20 – 2023/24.

Ministry of Health in Zanzibar (2019) Zanzibar Reproductive, Maternal, Newborn, Child and Adolescent Health Strategic Plan (2019 – 2023).

Ministry of Health in Zanzibar (2017) Mid Term Review Report of the Zanzibar Health Sector Strategic Plan III (2013/14-1018/19).

Ministry of Health in Zanzibar (2014) Health Sector Strategic Plan III (2013/14-1018/19).

Ministry of Health in Zanzibar (2014) "Road Map Strategic Plan to Accelerate the Reduction of Maternal, New-born and Child Deaths and Adolescent Health (2015-2018)"

Other documents

Bishanga, D. R., Charles, J., Tibaijuka, G., Mutayoba, R., Drake, M., Kim, Y. M., … Rawlins, B. (2018). Improvement in the active management of the third stage of labor for the prevention of postpartum hemorrhage in Tanzania: A cross-sectional study. *BMC Pregnancy and Childbirth*, *18*(1), 1–10. https://doi.org/10.1186/s12884-018-1873-3

Kruk, M. E., Gage, A. D., Arsenault, C., Jordan, K., Leslie, H. H., Roder-DeWan, S., … Pate, M. (2018). High-quality health systems in the Sustainable Development Goals era: time for a revolution. *The Lancet Global Health*, (18), 1–57. https://doi.org/10.1016/S2214-109X(18)30386-3

Maaløe, N., Andersen, C. B., Housseine, N., Meguid, T., Bygbjerg, I. C., & van Roosmalen, J. (2019). Effect of locally tailored clinical guidelines on intrapartum management of severe hypertensive disorders at Zanzibar's tertiary hospital (the PartoMa study). *International Journal of Gynecology & Obstetrics*, *144*(1), 27–36. https://doi.org/10.1002/ijgo.12692

Nababan, H. Y., Islam, R., Mostari, S., Tariqujjaman, M., Sarker, M., Islam, M. T., & Moucheraud, C. (2017). Improving quality of care for maternal and newborn health: a pre-post evaluation of the Safe Childbirth Checklist at a hospital in Bangladesh. *BMC Pregnancy and Childbirth*, *17*(1), 402. https://doi.org/10.1186/s12884-017-1588-x

Smith, J. M., Currie, S., Cannon, T., Armbruster, D., & Perri, J. (2014). Are national policies and programs for prevention and management of postpartum hemorrhage and preeclampsia adequate? A key informant survey in 37 countries. *Global Health: Science and Practice*, *2*(3), 275–284. https://doi.org/10.9745/GHSP-D-14-00034

Annex 4: Project Performance, Targets vs Actual

The table below compares performance of the project against its targets. Figures obtained at end-line are in the "orange" column "**CUMMULATIVE PROGRESS by DEC. 2019 (Endline Evaluation)".** The table further compares the values verified by the endline and those in the End of Project of Report, "green" column "**PROGRESS ASSESSMENT (EOP Report)".**

Colour codes:

Red: targets with no corresponding data for verification (red). Green: verified targets that were met; Yellow: Verified targets that were not met.

NO.	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMMULATIVE PROGRESS by SEPT. 2019 (EOP Report)	CUMMULATIVE PROGRESS by DEC. 2019 (Endline Evaluation)	TARGET	PROGRESS ASSESSMENT (EOP Report)	MEANS OF VERIFICATION	
								DATA SOURCES	DATA COLLECTION METHODS
ULTIMATE OUTCOME									
10000	Improved Health and wellbeing of women and children in Zanzibar	● Maternal mortality ratio	● 310/100000 (2013)	● 152/100000 (MOHZ-MPDSR 2018)		● 94/ 100,000	Good Progress	● MOHZ	● Routine HMIS
		● Under five mortality rate reduced	● 73/1,000 (2010)	● 56/1,000 (TDHS 2015/16)**15		● 24/1000	Data will be available in 2020 TDHS	● TDHS	● Survey
		● Stunting prevalence among children under five years reduced	● 24.4% (2014)	● 21.5% (TNNS 2018)		● 21%	Target met	● TNNS	● Survey
INTERMEDIATE OUTCOMES									

NO.	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMMULATIVE PROGRESS by SEPT. 2019 (EOP Report)	CUMMULATIVE PROGRESS by DEC. 2019 (Endline Evaluation)	TARGET	PROGRESS ASSESSMENT (EOP Report)	MEANS OF VERIFICATION	
								DATA SOURCES	DATA COLLECTION METHODS
11000	Strengthened health systems to deliver equitable and integrated health services including improvement of the referral system	Proportion of facilities with star rating of 3 and above	0% (2014)	● 5 out of 66 facilities assessed	6 HFs from 2018 assessment. (There was no fund for the assessment in 2019 although it was in a plan. Funds from UNICEF were not enough, hence prioritized for other activities).	7%	Underperformed due to start rating tool which assessed PHCU the same way as district hospitals and above. Minor revision to the tool yielded better results in 2019 than in 2018	HSRS	Accreditation reports
12000	Increased coverage of quality emergency obstetric care, newborn and child heath services, including high impact nutrition interventions	Proportion of deliveries at health facilities	56% (2013)	67% (DHIS2 2018)	65.6% (DHIS2)	80%	Not met	HMIS (Health bulletin)	Annual Health Bulletin
		Number of children (0-59 months) with severe acute malnutrition treated according to guidelines per year	1,250	3,417	636 out of 1175 (HMIS) (There is no directly related indicator in DHIS2).	5,200	Good progress. This represents 65% coverage of estimated SAM case load in Zanzibar. Technically the number of children with SAM is overestimated, making it difficult to meet this target. Child health and	MOHZ	Routine DHIS2

NO.	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMMULATIVE PROGRESS by SEPT. 2019 (EOP Report)	CUMMULATIVE PROGRESS by DEC. 2019 (Endline Evaluation)	TARGET	PROGRESS ASSESSMENT (EOP Report)	MEANS OF VERIFICATION	
								DATA SOURCES	DATA COLLECTION METHODS
							Nutrition month (CHNM) compains which covers more than 95% of children under-five have failed to identfy SAM cases.		
j									
11100	Strengthened HR capacity to deliver high quality RHNCH and nutrition services	Proportion of districts timely submitting quarterly progress reports	0 (2014)	10	10	10	Target met	ZHMTs	Quarterly progress report
11200	Strengthened HR capacity to deliver high quality RHNCH and nutrition services	Proportion of health facilities receiving 4 integrated MNCH supportive supervsion visits every year	60% (2013)	90%	In 2018 it was reported to be 40 out of 181 HFs (22.1%). In 2019 there was no supervision due to lack of funds from UNICEF (MOHZ Report)	100%	Good progress made. Gradual increase in number of HFs without proportional increase in resource allocation has been a challenge.	IRCHS	Monitoring reports
12100	Strategically placed district health facilties strengthened for provision of quality newborn, child and	Number of health facilities with fully functioning CEmONC services	4 (2014)	7	7 (MOHZ Reports)	6	Met and exceeded the target	HMIS	Routine HMIS data

NO.	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMMULATIVE PROGRESS by SEPT. 2019 (EOP Report)	CUMMULATIVE PROGRESS by DEC. 2019 (Endline Evaluation)	TARGET	PROGRESS ASSESSMENT (EOP Report)	MEANS OF VERIFICATION	
								DATA SOURCES	DATA COLLECTION METHODS
	24/7 EmONC services including emergency referral	Number of health facilities with fully functioning CEmONC services	1 (2014)	7	7 (MOHZ Report)	8	Good progress made.	HMIS	Routine HMIS data
12200	Strengthen community health systems to promote RMNCH care seeking behaviour and positive health, hygiene and nutrition practices, including by young people	Proportion of women attending all 4 ANC visits	48.9% (2010)	52.90%	77.1% (DHIS2)	60%	Good progress made.	TDHS	Survey
		Proportion of women and newborn attending at least 1 PNC visit within the first 2 days after delivery	32.4% (2010)	38.40%	94.2% (Women) 88.7% (Newborn) (DHIS2)	60%	Good progress made.	HMIS	Survey
		Percentage of household that have soap and who report having used soap for hand washing at least at twocritical times during past 24 hours	13.2% (2014)	1%		30%		TNNS	Survey
		Proportion of infants 0-5 months of age who are fed exclusively with breast milk	20% (2014)	30% (2018)		40%	Good progress made TNNS	TNNS	Survey

NO.	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMMULATIVE PROGRESS by SEPT. 2019 (EOP Report)	CUMMULATIVE PROGRESS by DEC. 2019 (Endline Evaluation)	TARGET	PROGRESS ASSESSMENT (EOP Report)	MEANS OF VERIFICATION	
								DATA SOURCES	DATA COLLECTION METHODS
		Proportion of children aged 6 to 23 months receiving a minimum acceptable diet	8% (2014)	14%		20%	Good progress made	TNNS	Survey
OUTPUTS									
11110	Improved annual planning and monitoring for RMNCH in Zanzibar	Proportion of districts which have developed satisfactory CDHPs that incorporate RMNCAH	0	100% (11 of 11 districts)	100% (11 of 11 districts)	100% (11 of 11 districts)	Achieved. Quality imlprovement support is being provided.	Districts annual Plan	District Planning Meeting
11120	Improved peformance and accountability of RMNCH services in Zanzibar	Proportion of districts and zones conducting regular maternal and perinaal death review meetings	0 (2014)	● 100% zones (2)	100	● 100% zones (2)	On track. Regular reviews done after maternal and / or perinatal deaths	IRCH	Quarterly MPDSR reports
				● 100% districts (11/11)	100% (11 of 11 districts)	● 70% districts (8/11)			
11130	Strengthened RMNCH supply management system	Proportion of facilities without stock-out of essential medical supplies throughout the year	0% (2014)	85%	90% (2018) (ILS reports)	50%	Achieved	IRCH/ CMS (Life saving commodities reports)	Quarterly report
11210	Existing staff development and retention policies reviewed and operationalised	Percentage of Health Care Professionals retained	TBD in baseline (16)	NA	NA (HRIS not functioning)	At least 98%	HRIS presently nor functioning nor updated	Baseline staff attrition assessment & HRIS and training report	HR Bulletin (Report)

NO.	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMMULATIVE PROGRESS by SEPT. 2019 (EOP Report)	CUMMULATIVE PROGRESS by DEC. 2019 (Endline Evaluation)	TARGET	PROGRESS ASSESSMENT (EOP Report)	MEANS OF VERIFICATION	
								DATA SOURCES	DATA COLLECTION METHODS
11220	Innovative approaches to staff development established and implemented	Number of new learning approaches integrated in the training programe	0	2		3	On Track. The 3 innovative learning approaches include: Task shifting; Mentorship; Use of ICT and Distance learning	Annual Joint Health Sector Review	CHS report
		Number of Innovations implemented	0	2		3			
11230	Increased availability of high and mid-level skilled health workers for RMNCH services provision	Number of skilled health care workers met by 50% of established need	TBD (17)	N/A		75%	HRIS system is not functiong with outdated data	HRIS	Training report & Deployment committee meeting report
12110	Improved capacity of selected facilities to provide quality newbord, child and EmoNC services	Proportion of health facilities with at least two health providers who have received training on distance learning IMCI and Essential Newborn Care	68%	100%	85% (MoHZ-IMCI report)	80%	Achieved	(2016 IMCI report)	Supervision report and annual report (Training data base IRCH)
		Proportion of health facilities conducting maternal and perinatal death reviews	2.40%	100%	100% (52 0f 52 HF) (2018 MOHZ Report)	100%	Target Met	(HMIS 2013)	HMIS report

NO.	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMMULATIVE PROGRESS by SEPT. 2019 (EOP Report)	CUMMULATIVE PROGRESS by DEC. 2019 (Endline Evaluation)	TARGET	PROGRESS ASSESSMENT (EOP Report)	MEANS OF VERIFICATION	
								DATA SOURCES	DATA COLLECTION METHODS
12120	Improved infrastructure for delivery of 24/7 EmONC services in selected health facilities includingemergency referral	Caesarean Sections as a proportion of all births	4% (2013)	8.10%	9.1% (DHIS2)	5%	Target met	(HMIS)	HMIS report 2018
		Proportion of all deliveries in basic and comprehensive EmONC facilities	26% (2013)	44%		35% (There is no report to indicate which facilities qualify to be BEmONC and/or CEmONC. No recent assessment om signal functions)	Target met and exceeded	(HMIS)	HMIS report
12130	Increased accessibility and availability of safe blood and components	Blood Bank freezer and refrigerator functional	1 Blood Bank freezer and 1 refrigerator functinal (2014)	2	2 Blood Bank freezers and 2 refrigerators functional (ZNBTS report)	2 Blood Bank freezers and refrigerators functionaaal	Target met	ZNBTS	Annual routine data

NO.	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMMULATIVE PROGRESS by SEPT. 2019 (EOP Report)	CUMMULATIVE PROGRESS by DEC. 2019 (Endline Evaluation)	TARGET	PROGRESS ASSESSMENT (EOP Report)	MEANS OF VERIFICATION	
								DATA SOURCES	DATA COLLECTION METHODS
		Number of safe blood units collected and distributed to health facilities	9,500 (2013/2014)	13,837 units distributed out of 15,057 unts collected	For the period of July 2017-June 2018: 13,565 units collected, and 10,233 units distributed. For the period of July 2018-June 2019: 15,052 units collected, and X units distributed. (ZNBTS reports)	10,000	Target met	ZNBTS	Annual routine data 2018/2019
		Percentage of blood units processed into components	48% (2013/2014)	76%		80%	Good progress	ZNBTS	Annual routine data
12140	Strengthened youth friendly SRH/FP service provision in selected districts	Number of youths utilized SRH/FP services	1,355 (2014)	4,539	1,526 new adolescents and young people aged 15-24 who received FP counseling in 2019, and cumulative total of 6,331 youths for a period of 2016 to 2019(DHIS2)	10,000	On track.	RCH /HMIS	Quarter progress report

NO.	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMMULATIVE PROGRESS by SEPT. 2019 (EOP Report)	CUMMULATIVE PROGRESS by DEC. 2019 (Endline Evaluation)	TARGET	PROGRESS ASSESSMENT (EOP Report)	MEANS OF VERIFICATION	
								DATA SOURCES	DATA COLLECTION METHODS
12210	Increased proportion of health faciliteis with at least one health worker trained worker trained to provide promotional RHNCH WASH and Nutrition services	Proportion of health facilities with at least one health worker trained to provide promotional RMNCH, WASH and Nutrition services	0 (2014)	100%	No HRH database at the Ministry on HCWs trained by health facility	80%	Target met	Training register and reports	Programme monitoring and supervision
12220	Increased proportion of Shehias with at least one community health worker trained to provide screening and referral for malnutrition and promote RMNHCH care seeking behaviour	Proportion and number of Shehias with at least one community health volunteer trained to provide promotional RMNCH, WASH and Nutrition services, provide screening and referral for malnutrition and promote RMNCH care seeking behaviour	0 (2014)	86% (333)	85% (332 of 389) (Project reports)	80%	Target met	Training registers and reports	Programme monitoring and supervision
12230	Increased number of pregnant women, caregivers of children below five and adolescents participating in promotional RMNCH, WASH and nutrition services	Number of pregnant women, caregivers of children under 5 years old and adolescents participating in promotional RMNCH, WASH	0 (2014)	● 102, 621 caregivers, (131%) ● 42, 354 pregnant women (94%)	In 2019: 117,965 Cumulative total: 322,565 (Project reports) In 2019: 12,863 Cumulative	● >78,000 care givers of children under 5 ● 45,000 pregnant women	Target met and exceeded for caregivers. Target nearly met for pregnant women. Good progress made for adolescents	CHVs reports	Meetings among CHVs and supervisors, PHCUs and Shehias

NO.	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMMULATIVE PROGRESS by SEPT. 2019 (EOP Report)	CUMMULATIVE PROGRESS by DEC. 2019 (Endline Evaluation)	TARGET	PROGRESS ASSESSMENT (EOP Report)	MEANS OF VERIFICATION	
								DATA SOURCES	DATA COLLECTION METHODS
		and nutrition servsices per year			total: 43,038 (Project reports)				
				● 64, 632 adolescents (81%)	In 2019: 55,980 Cumulative total: 154,059 (Project reports)	● 80,000 adolescents			
12240	Increased coverage of promotional RMNCH, WASH and nutrition programs delivered through medias and schools	Number of persons reached with radio spots on RMNCH, WASH and nutrition messages per year	0 (2014)	50,600	Data was not available from the Ministry	400,000 persons	Target met and exceeded	HPU	Media coverage surveys
		Number of students reached by teachers with RMNCH, WASH and nutrition messages per year	0 (2014)	18, 541 students	Data was not available from the Ministry	5,000 students	Target met and exceeded	Teachers reports	Monitoring
12250	Improved coordination, monitoring and supervision of community health activities	Proportion of Shehias with Health Custodian Committees holding at least two meetings with community health workers activities per year	0 (2014)	100%	Data not collected	80%	Target met and exceeded	Progress reports	Monitoring

NO.	EXPECTED RESULTS	INDICATORS	BASELINE DATA	CUMMULATIVE PROGRESS by SEPT. 2019 (EOP Report)	CUMMULATIVE PROGRESS by DEC. 2019 (Endline Evaluation)	TARGET	PROGRESS ASSESSMENT (EOP Report)	MEANS OF VERIFICATION	
								DATA SOURCES	DATA COLLECTION METHODS
		Number of six-monthly monitoring/review meetings at zonal level organized every year	0 (2014)	2	2 meetings per year (MOHZ Reports)	2 zonal meetings			

Annex 5: Additional Analysis of Quantitative Data

Table A5-1: Distribution List of Medical Equipments for Specific Delivery Facilities

Distribution List of Medical Equipments for Specific Delivery Facilities	
Health facility	No. of Equipments
Tumbatu Kask.Pemba	50
Fuoni PHCU+ Magharibi	72
Sebleni Mjini PHCU+	66
MMH Hospital	14
Bogoa Mkoani PHCU+	57
Wete District Hospital	11
Junguni PHCU+ Wete	48
Uondwe PHCU+ Wete	53
Micheweni Hospital	25
Chakechake Hospital	26

Figure A5-1: Distribution List of Medical Equipments for Specific Delivery Facilities

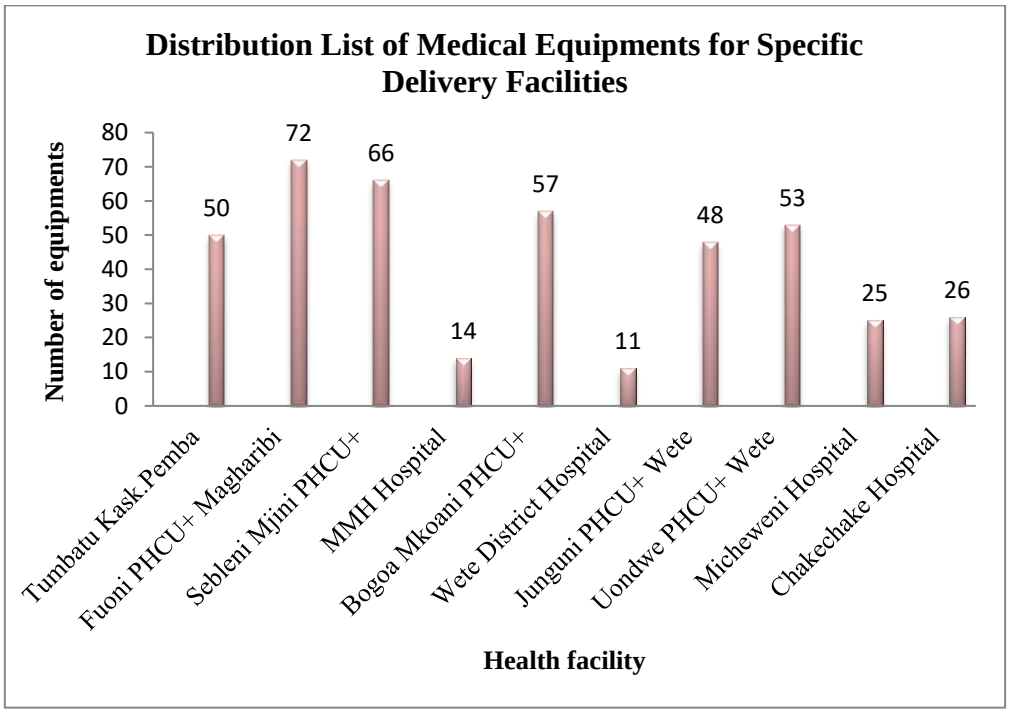


Table A5-2: Retention to the work station after training

Retained	Not retained
88%	12%

Figure A5-2: Retention to the work station after training

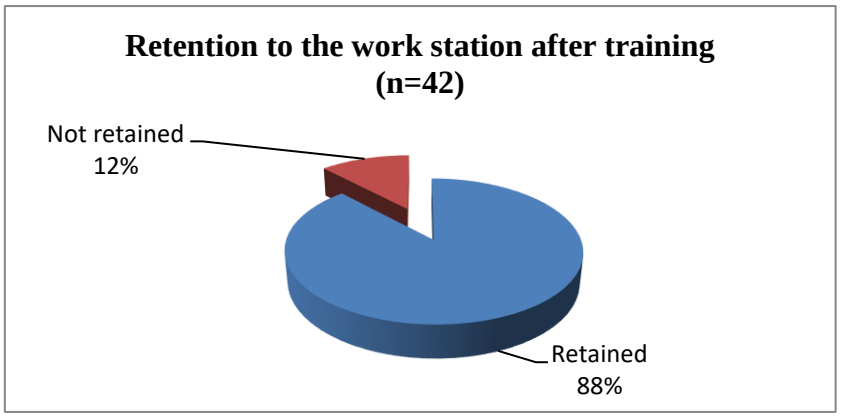
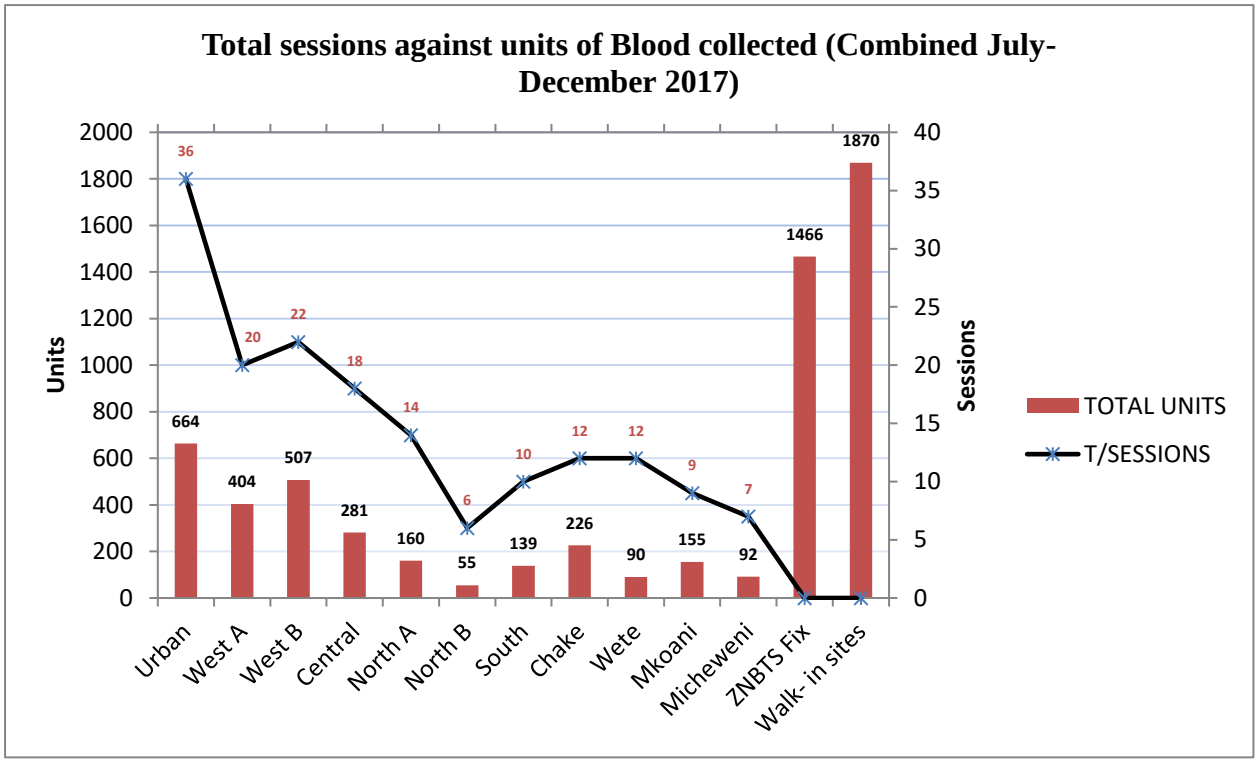


Table A5-3: Total session against units (Combine July-Sep and Oct-December 2017)

District	T/SESSIONS	TOTAL UNITS
Urban	36	664
West A	20	404
West B	22	507
Central	18	281
North A	14	160
North B	6	55
South	10	139
Chake	12	226
Wete	12	90
Mkoani	9	155
Micheweni	7	92
ZNBTS Fix	0	1466
Pemba Fix	0	290
Walk in-sites	0	1580
Total	**166**	**6109**

NB: Pemba Fix is part of walk in-sites

Figure A5-3: Total sessions against units of Blood collected (Combined July-December 2017)



NBTS Activity report _MDAs

Table A5-4: Community sensitization sessions followed by blood collection July to Dec 2017 (n=6109 units)

Duration	Walk in sites	Mobile sensitization blood	Total units collected	Sessions
July 2017 – Sept 2017	1580 (25.9%)	1454 (23.8%)	3034 (49.7%)	88
Oct 2017 – Dec 2017	1747 (28.6%)	1328 (21.7%)	3075 (50.3%)	78
Total	3327 (54.4%)	2782 (45.6%)	6109 (100%)	166

Figure A5-4: Community sensitization sessions followed by blood collection July to Dec 2017

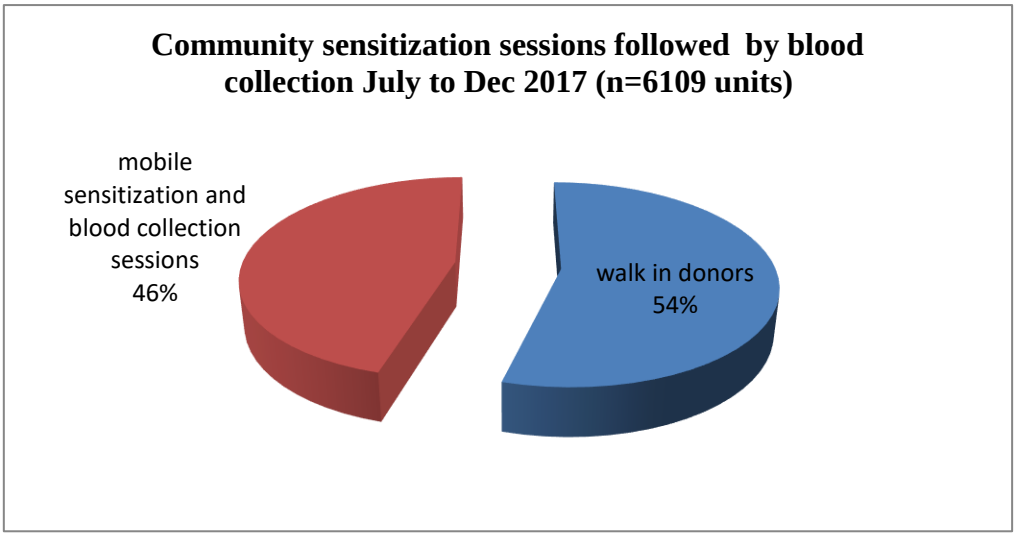


Table A5-5: Total units of blood collected and its distribution (July 2017- June 2019)

Duration	Total blood units	Distribute to hospitals
July 2017 - June 2018	**13565**	**10233**
July 2018 – June 2019	**15052**	—
Total	**28617**	

COMPILED ANNUAL DATA HIS

Table A5-6: Maternal health

Pregnant women starting ANC before 12 weeks					
Years	2015	2016	2017	2018	2019
Total number of pregnant women who attended ANC clinic before 12 weeks of their gestation period	12283	12926	14859	16556	8305
Total number of pregnant women who attended ANC clinic for the 1st time	51340	53803	62157	63182	62556
Proportion (%)	23.9	24	23.9	26.2	13.3

Figure A5-5: Pregnant women starting ANC before 12 weeks

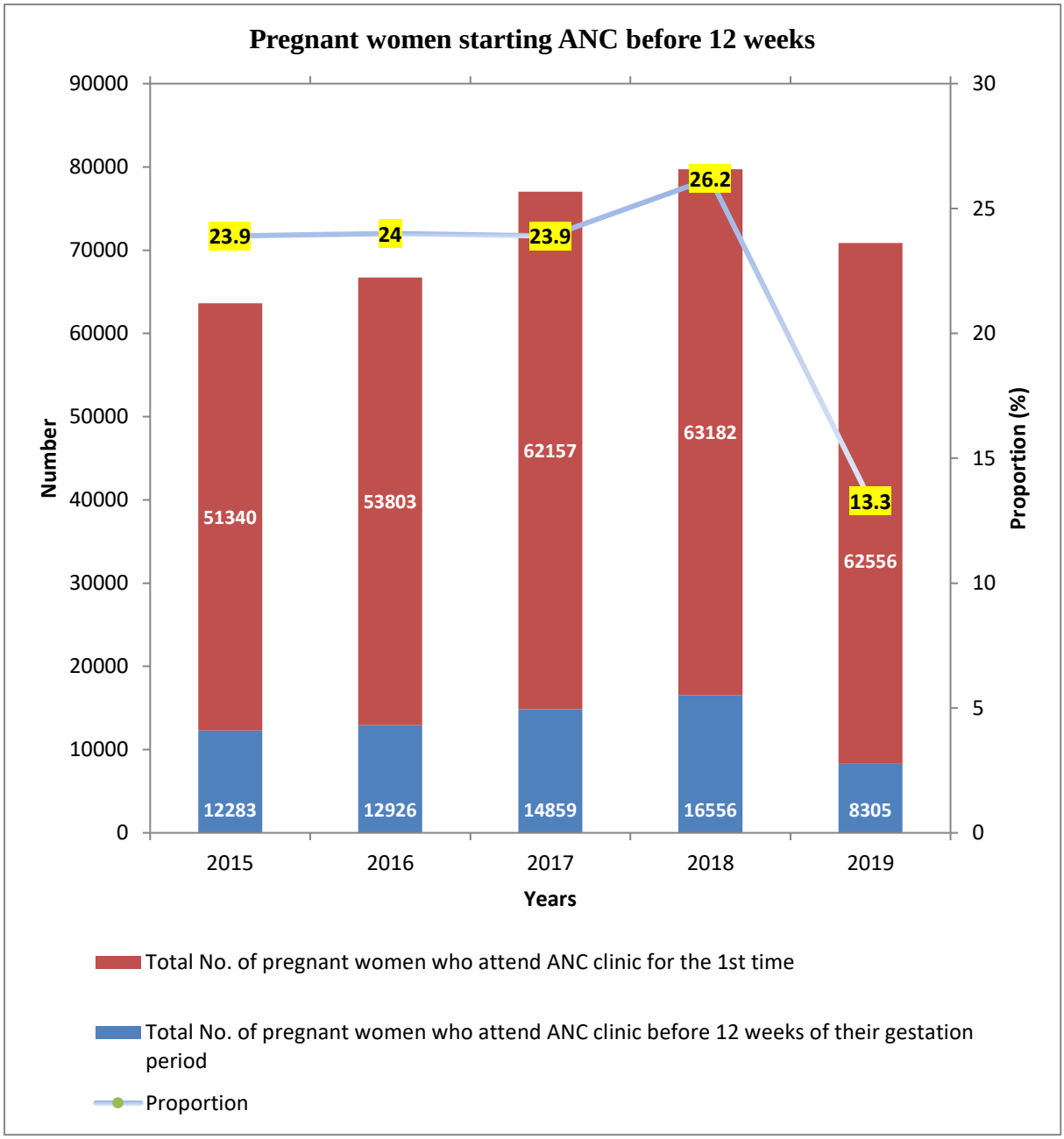


Table A5-7: Proportion of maternal deaths audited at facility

Proportion of maternal deaths audited at facility		
Years	2018	2019
Numerator (maternal deaths audited)	50	63
Denominator (total maternal deaths)	70	71
Proportion (%)	71.4	88.7

Table A5-8: Caesarean section cases

Years	2015	2016	2017	2018	2019
Caesarean cases	2,659	2,908	3,429	3691	4,148
Total deliveries	33,712	34,563	42,360	42165	45,791
Proportion (%)	7.9	8.4	8.1	8.8	9.1

Figure A5-6: Caesarean section cases

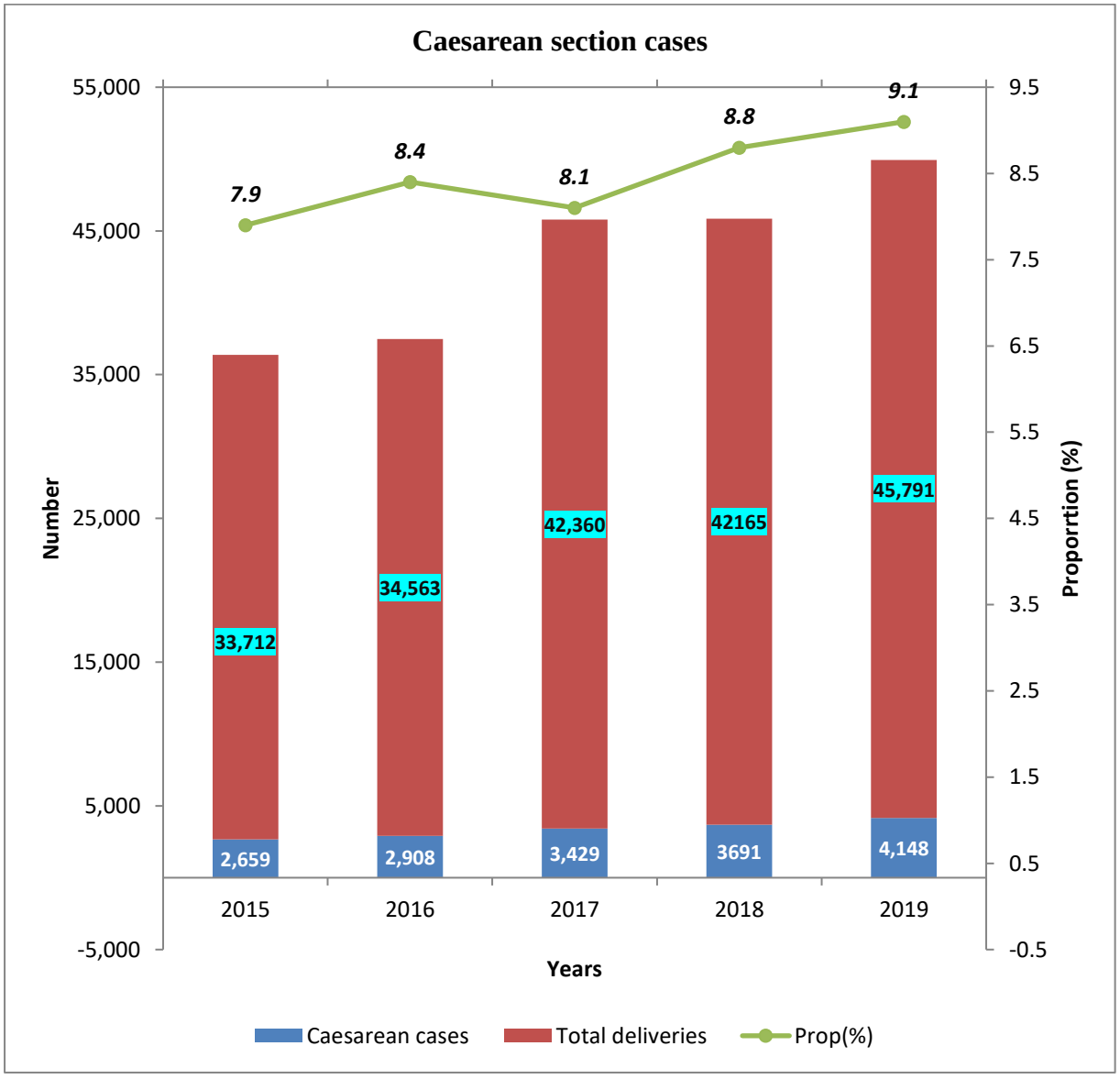


Table A5-9: Pregnant women who received 4 or more ANC contacts in a given time period

Years	2015	2016	2017	2018	2019
Total number of pregnant women who received 4 or more ANC contacts	14199	15438	19452	21855	35299
Total ANC visits	33712	34563	42360	42165	45791
Proportion (%)	42.1	24	45.9	51.8	77.1

Figure A5-7: Pregnant women who received 4 or more ANC contacts in a given time period

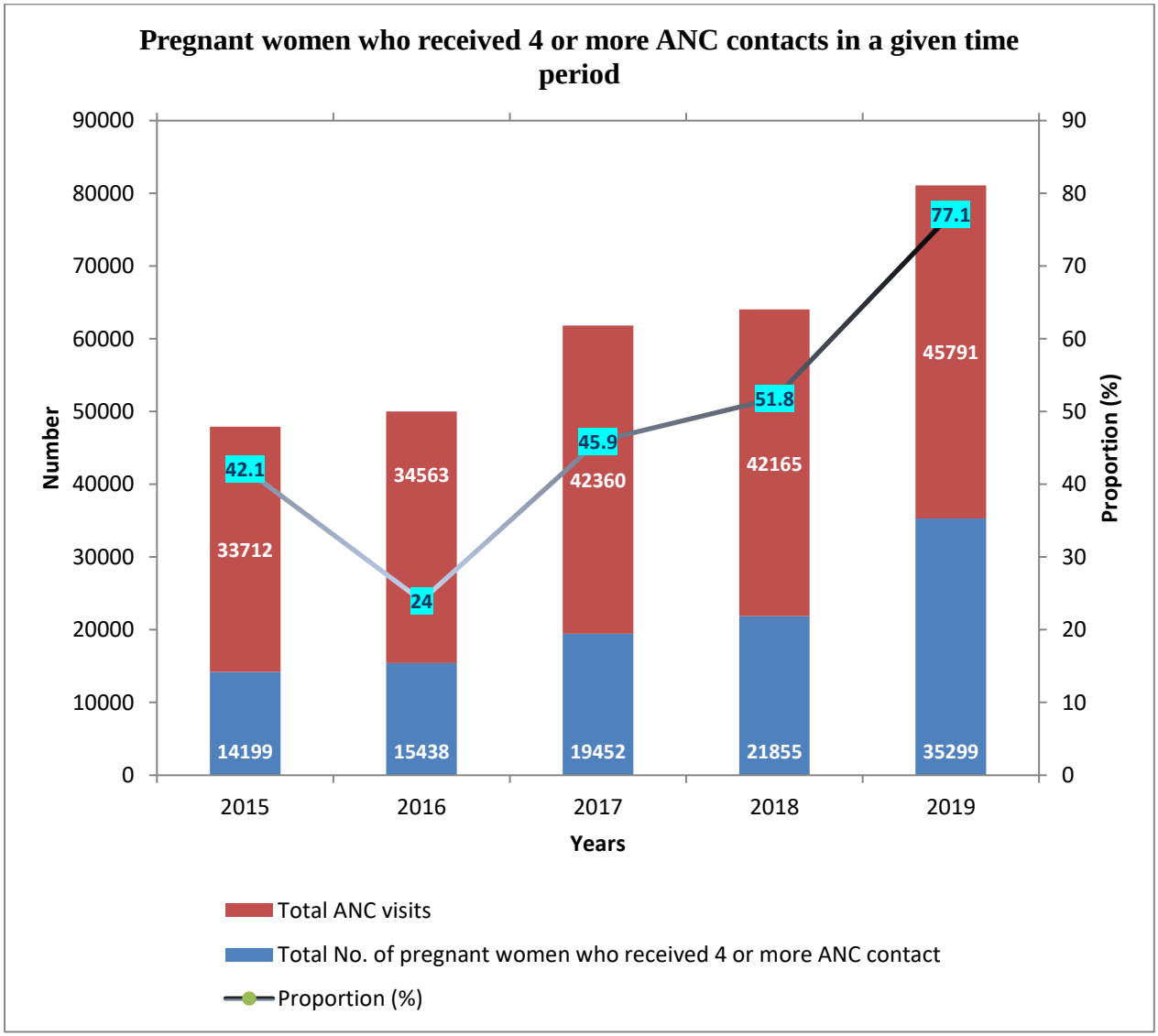


Table A5-10: Proportion of mothers receiving PNC within 48 hours

Years	2015	2016	2017	2018	2019
Numerator (PNC within 48 hrs)	2,909	3,792	8,764	32127	43,117
Denominator (Total deliveries)	33,712	34,563	42,360	42165	45,791
Proportion (%)	8.6	11.0	20.7	76.2	94.2

Figure A5-8: Mothers receiving PNC within 48 hours

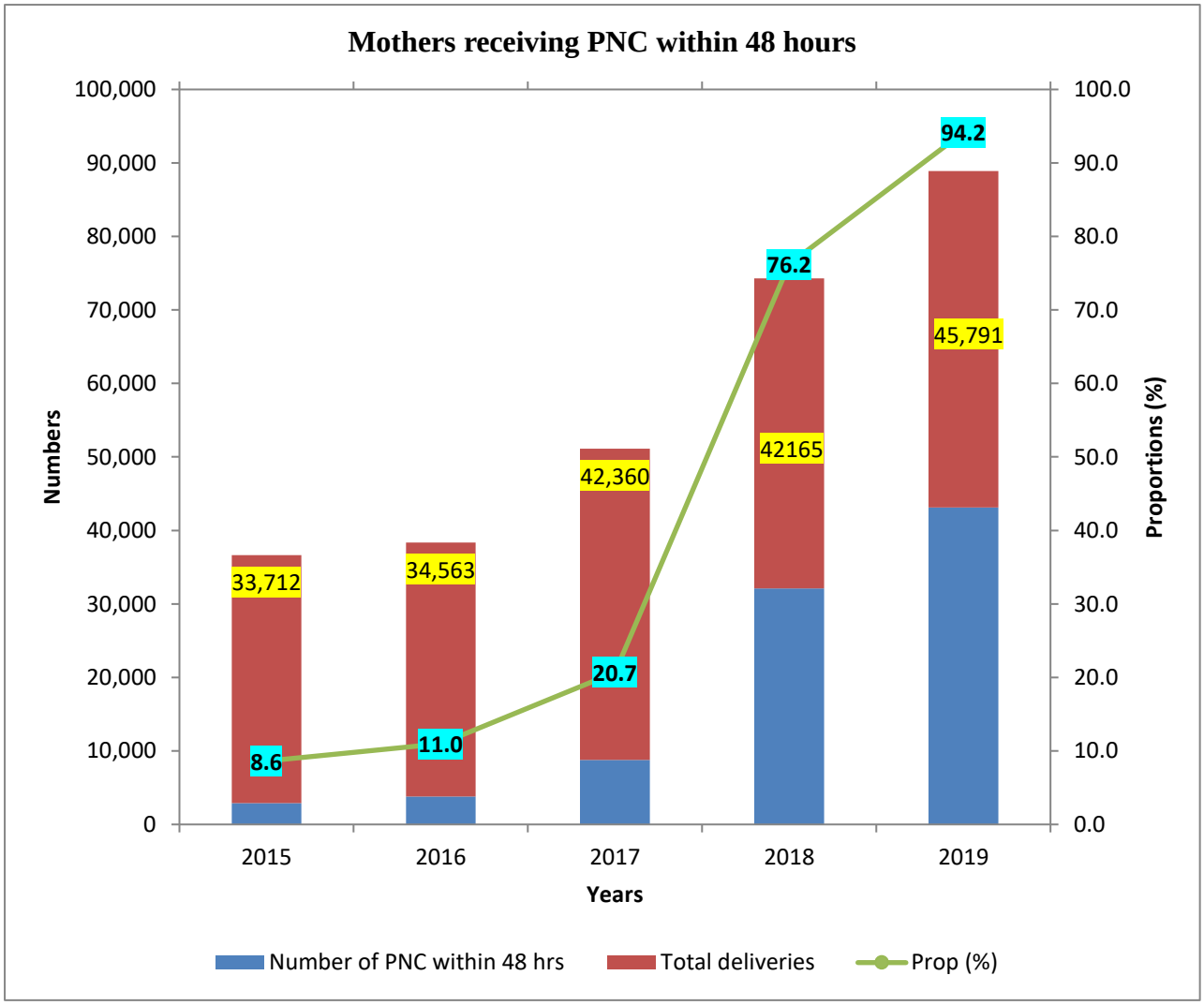
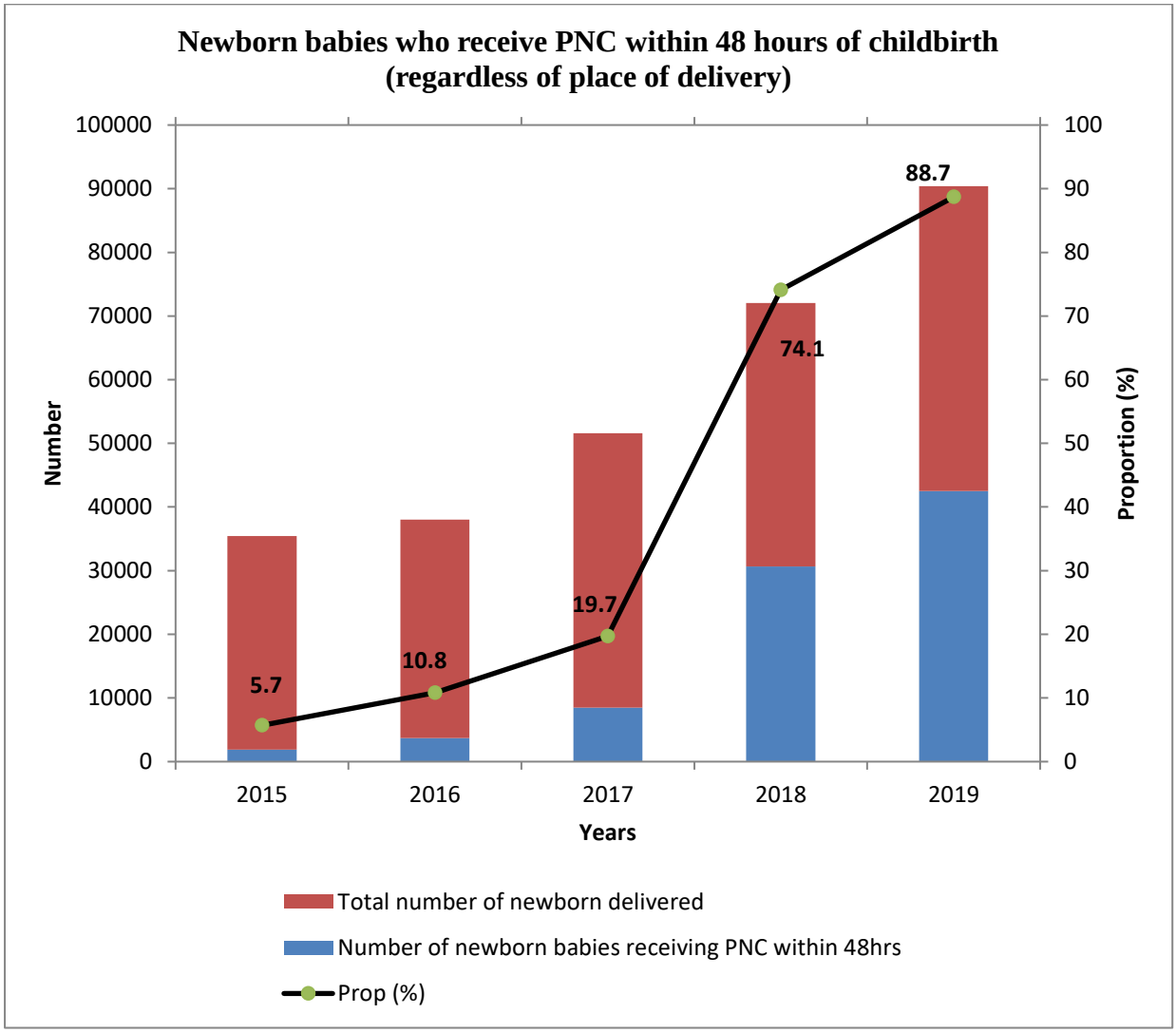


Table A5-11: Newborn babies who receive PNC within 48 hours of childbirth (regardless of place of delivery)

Years	2015	2016	2017	2018	2019
Numerator (PNC within 48 hrs)	1899	3695	8473	30669	42496
Denominator (Total deliveries)	33523	34334	43110	41364	47903
Proportion (%)	5.7	10.8	19.7	74.1	88.7

Figure A5-9: Newborn babies who receive PNC within 48 hours of childbirth (regardless of place of delivery)

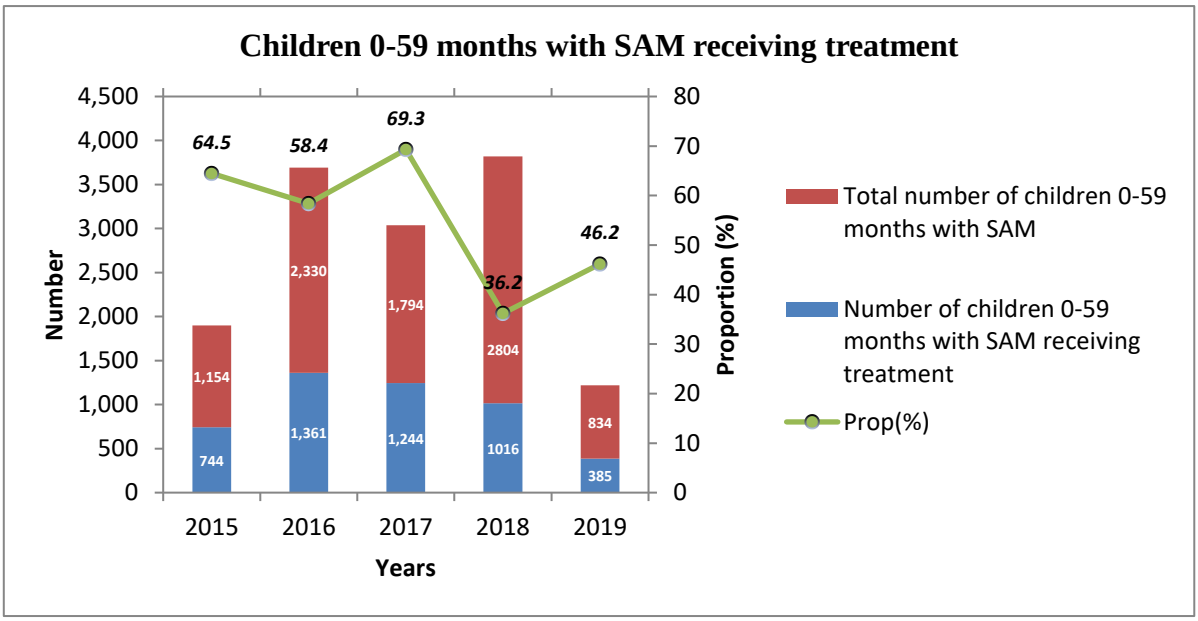


Nutrition Health

Table A5-12: Children 0-59 months with SAM receiving treatment

Years	2015	2016	2017	2018	2019
Number of children 0-59 months with SAM receiving treatment	744	1,361	1,244	1016	385
Total number of children 0-59 months with SAM	1,154	2,330	1,794	2804	834
Proportion (%)	64.5	58.4	69.3	36.2	46.2

Figure A5-10: Children 0-59 months with SAM receiving treatment



Adolescent Health

Table A5-13: New adolescents and young people aged 15-24 who receive FP counseling (Youth)

Years	**2015**	**2016**	**2017**	**2018**	**2019**
No. of new youth people aged 15-24 receiving FP counseling	952	1,007	919	2,879	1,526
Total number of new youth aged 15-24 years	1271	1634	1056	3006	4355
Proportion (%)	74.9	61.6	87	95.8	35

Figure A5-11: New adolescents and young people aged 15-24 who receive FP counseling (Youth)

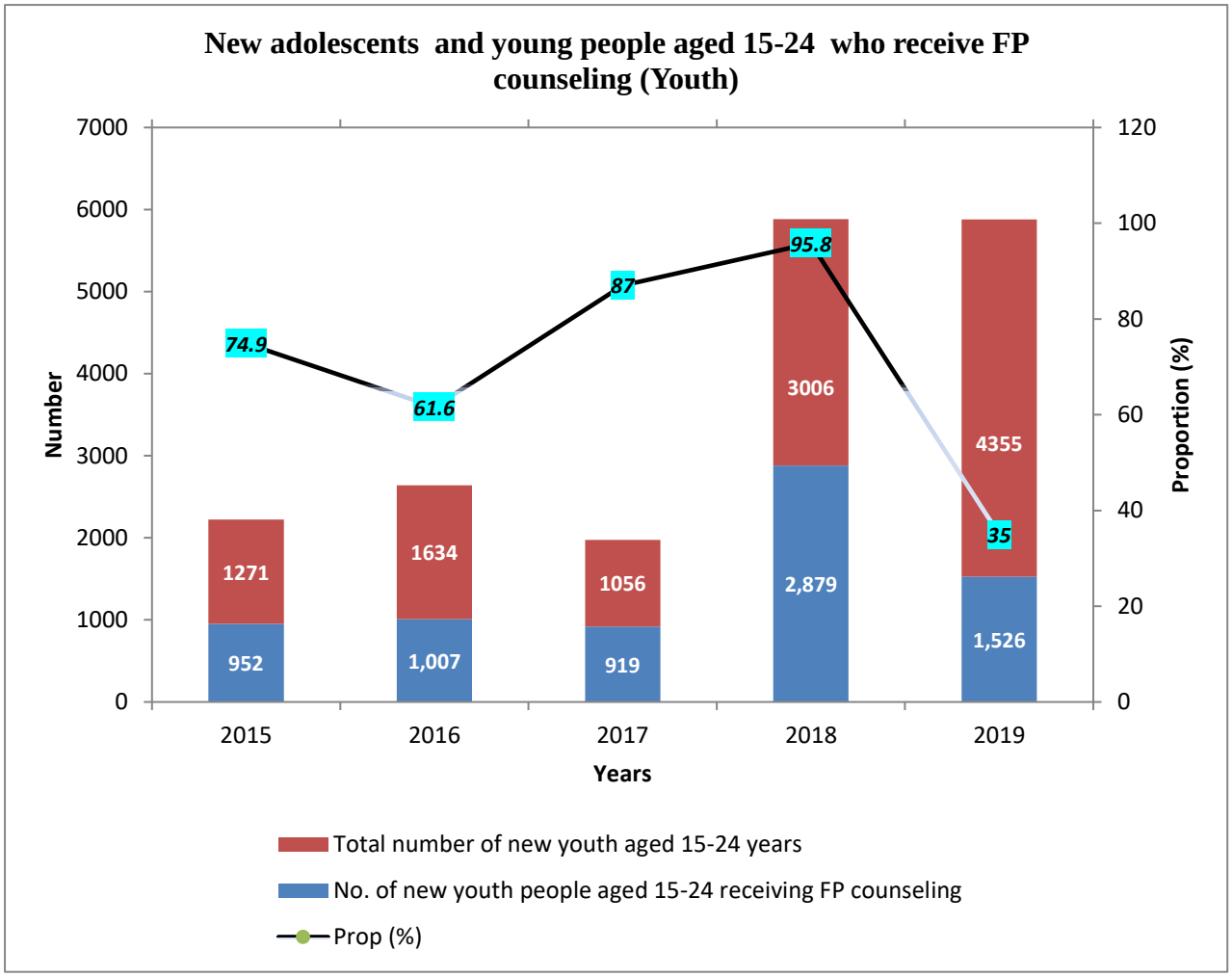


Table A5-14: New adolescents and young people aged 15-24 who receive any modern FP method

Years	2015	2016	2017	2018	2019
Number of new youth aged 15-24 who receive any modern FP method	260	293	195	554	697
Total number of new youth aged 15-24	952	1007	1354	2879	1150
Proportion (%)	27.3	29.1	14.4	19.2	60.6

Figure A5-12: New adolescents and young people aged 15-24 who receive any modern FP method

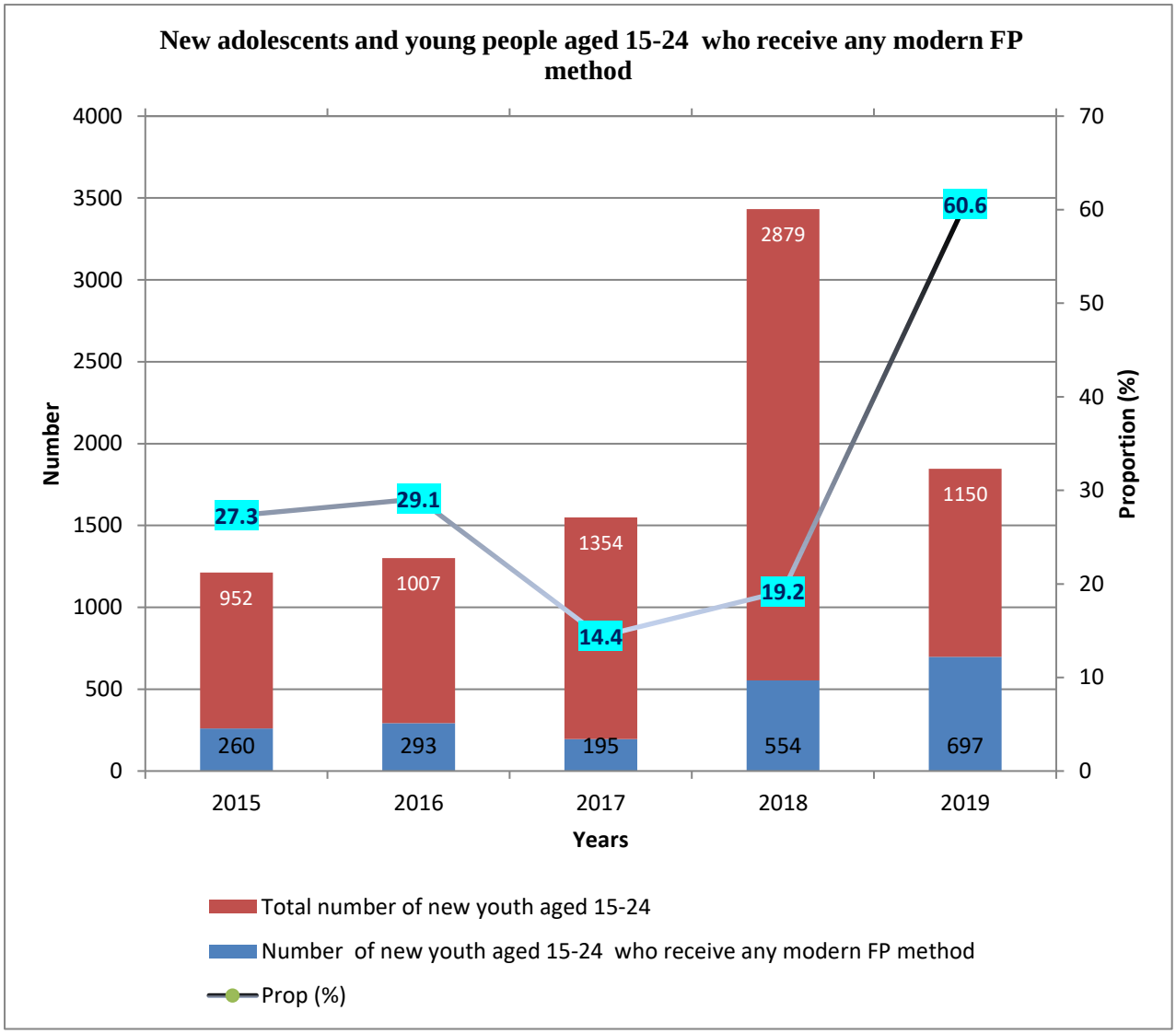


Table A5-15: Adolescents (below 20 years) who delivered at a health facility from among all women who deliver at a health facility

Years	2015	2016	2017	2018	2019
Number of adolescents (below 20 years) who delivered at a health facility	3,069	3,083	3,473	3,109	2,855
Total number of women delivering at a HF	33,712	34,563	42,360	42,165	45,791
Proportion (%)	9.1	8.9	8.2	7.4	6.2

Figure A5-13: Adolescents (below 20 years) who delivered at a health facility from among all women who deliver at a health facility

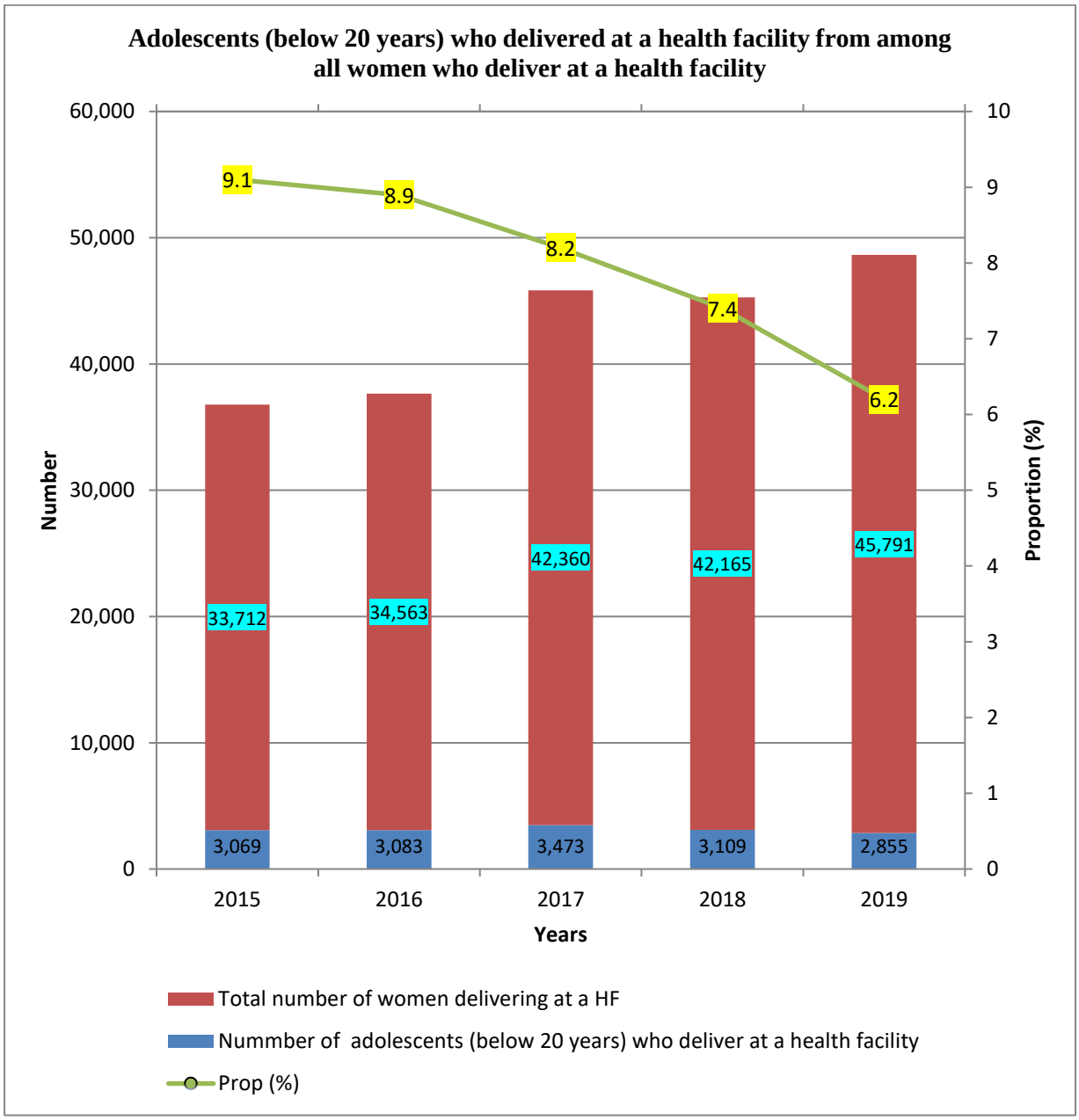


Table A5-16: Proportion of facilities without stock out of supply (RMNCAH) throughout a year

Years	2015	2016	2017	2018
Number of facilities without stock-out	141	145	147	148
Total number of facilities	150	156	160	164
Proportion (%)	94	93	92	90

Figure A5-14: Proportion of facilities without stock out of supply (RRMNCAH) throughout a year

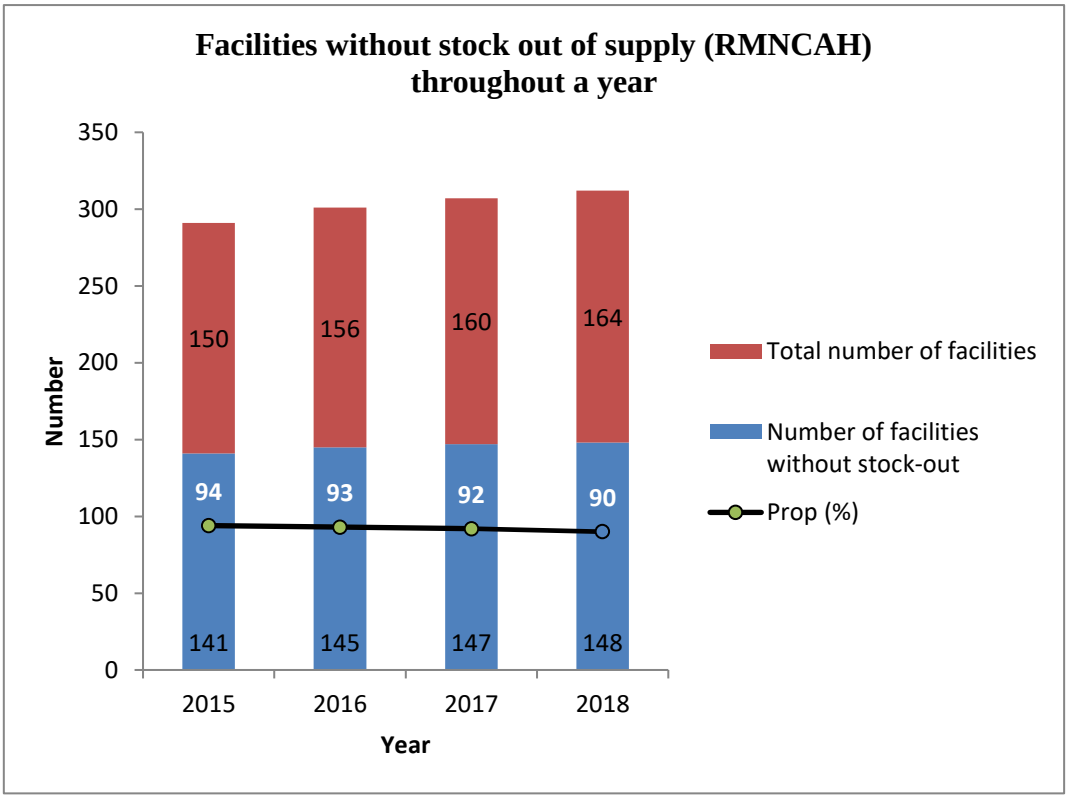


Table A5-17: No. of HFs reporting stock out

Years	2015	2016	2017	2018
No. of HFs reporting stock out	9	11	13	17

Figure A5-15: Health facilities reporting stock out

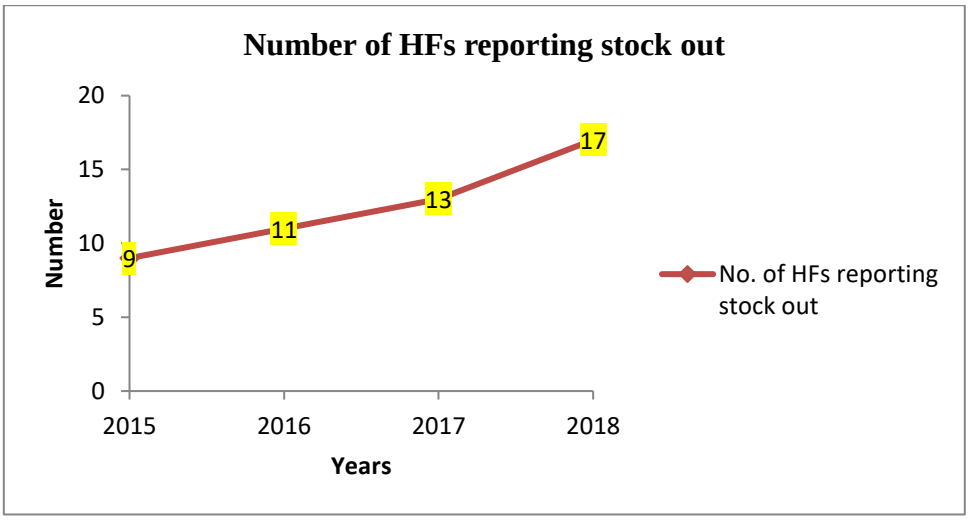


Table A5-18: Facilities reporting no stock out (of RMNCAH supply) during the past quarter

Years	2015	2016	2017	2018	2019
Proportion (%)	94	93	92	90	92

Figure A5-16: Proportion of facilities reporting no stock out (of RMNCAH supply) during the past quarter

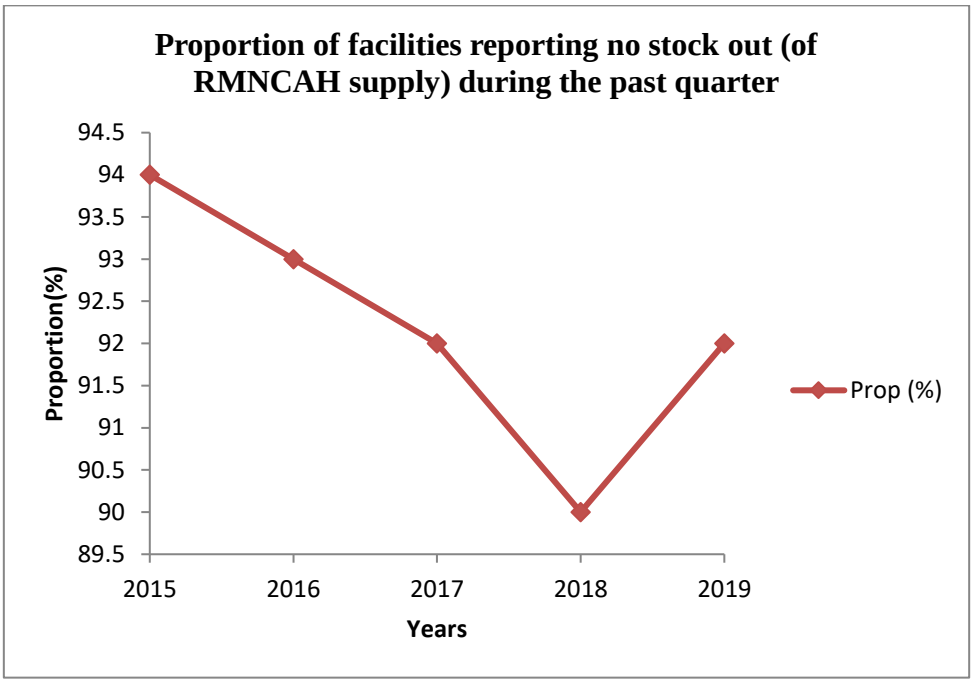
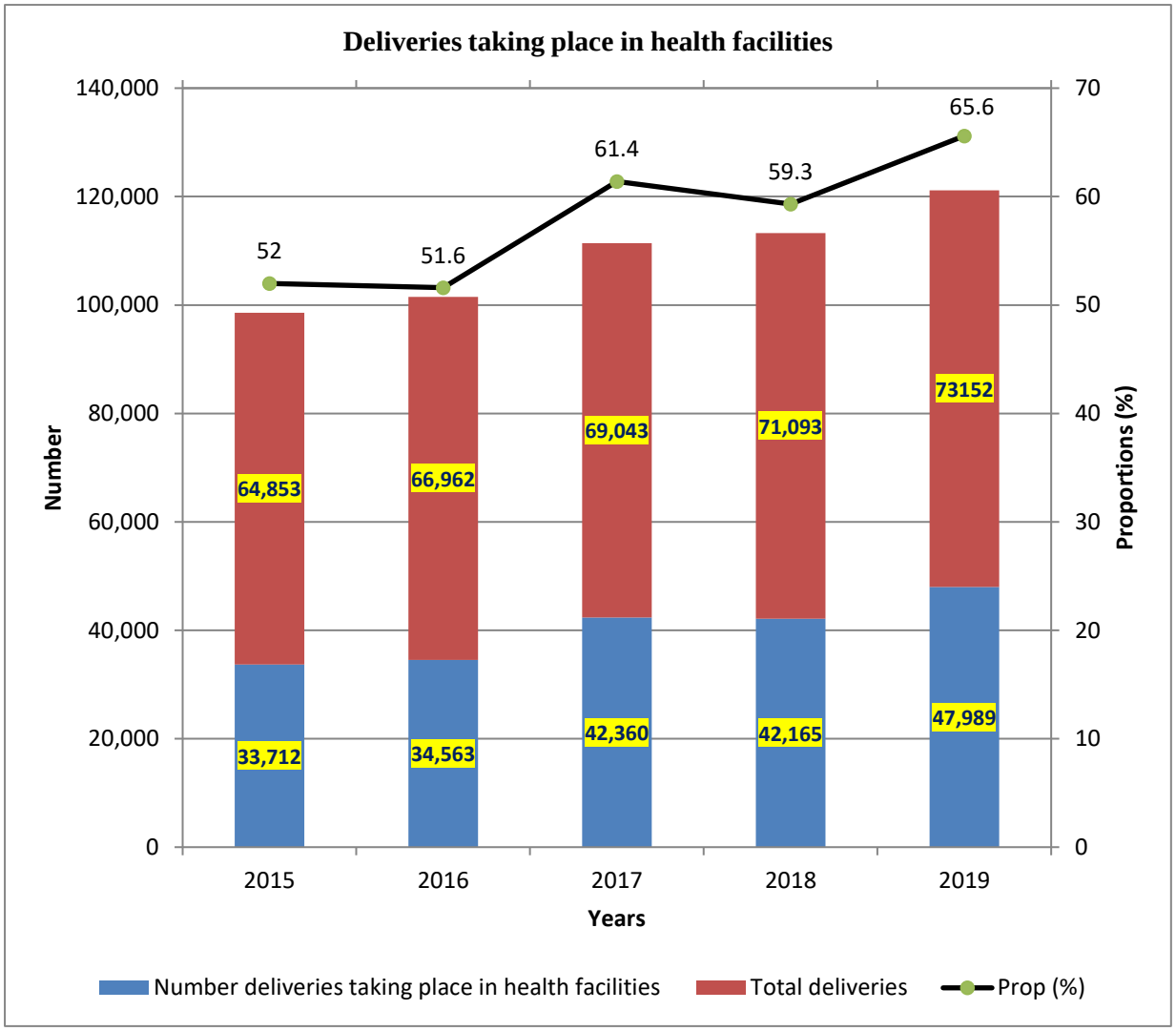


Table A5-19: Deliveries taking place in health facilities

Years	2015	2016	2017	2018	2019
Facility deliveries	33,712	34,563	42,360	42,165	47,989
Total expected deliveries	64,853	66,962	69,043	71,093	73152
Proportion (%)	52	51.6	61.4	59.3	65.6

Figure A5-17: Deliveries taking place in health facilities



Compiled MOHZ and Project Report

Table A5-20: Proportion of health facilities with at least two health providers who have received training on distance learning IMCI

Year	2016	2017	2018	2019
HFs with trained providers	153	153	153	153
Total HFs	171	171	181	181
Proportion (%)	89	89	85	85

Figure A5-18: Proportion of health facilities with at least two health providers who have received training on distance learning IMCI

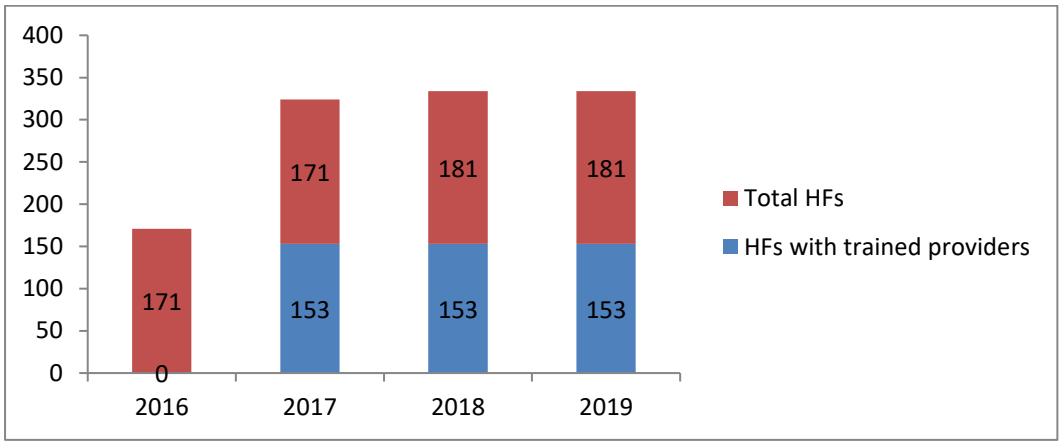


Table A5-21: Health facilities with at least two health providers who have received training Essential New-born Care

Year	2016	2017	2018	2019
HFs with trained providers	45	45	45	45
Total HFs (providing deliveries)	45	52	52	52
Proportion (%)	100	87	87	87

Figure A5-19: Health facilities with at least two health providers who have received training Essential New-born Care

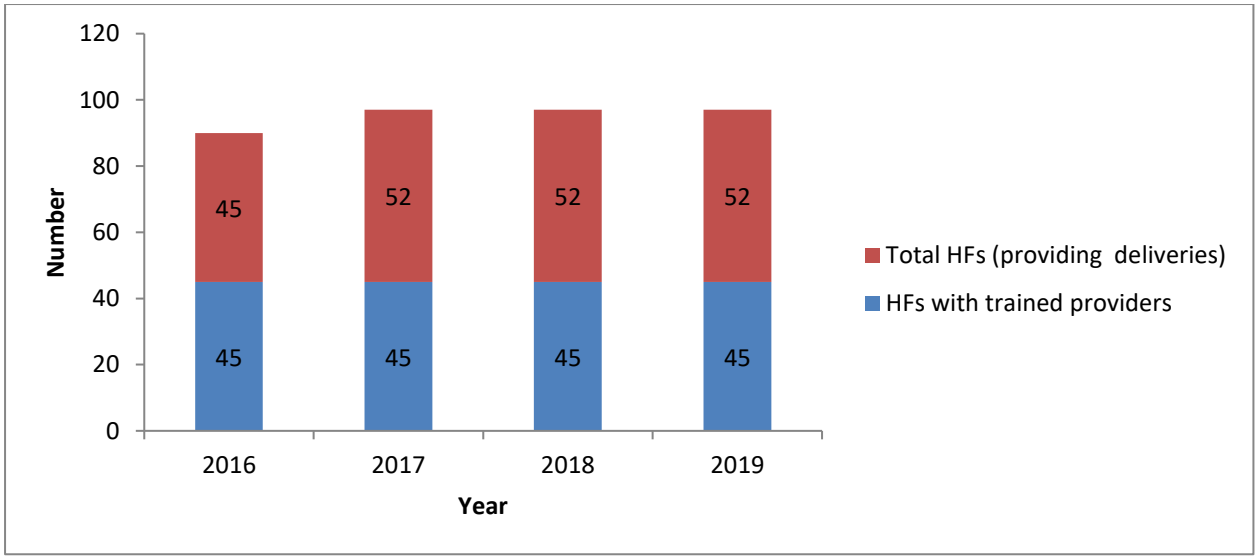


Table A5-22: Health facilities conducting maternal and perinatal death reviews

Year	2015	2016	2017	2018
HFs with MPDSR	0	0	52	52
Total HFs	45	45	52	52
Proportion (%)	0	0	100	100

Out of 45 health facilities in each year (2015 & 2016) there were no health facilities conducting maternal and perinatal death reviews. In 2017 and 2018 there were 52 health facilities in each year and all they were conducting maternal and perinatal death reviews.

Table A5-23: Proportion of health facilities receiving 4 integrated RMNCAH supportive supervision visits per year

Year	2015	2016	2017	2018	2019
HFs with Integrated Supportive Supervision (ISS)	20	40	36	40	0
Total HFs	171	171	171	181	181
Proportion (%)	12	23	21	22	0

Figure A5-20: Health facilities with at least two health providers who have received training Essential New-born Care

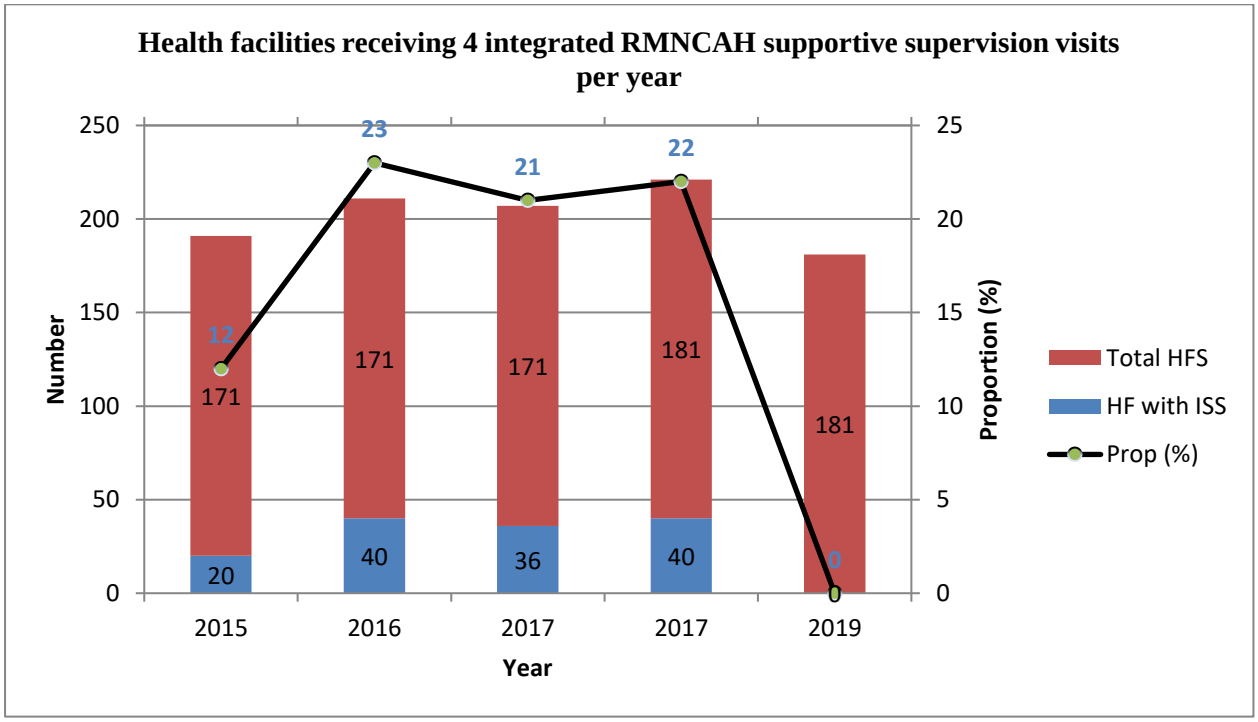
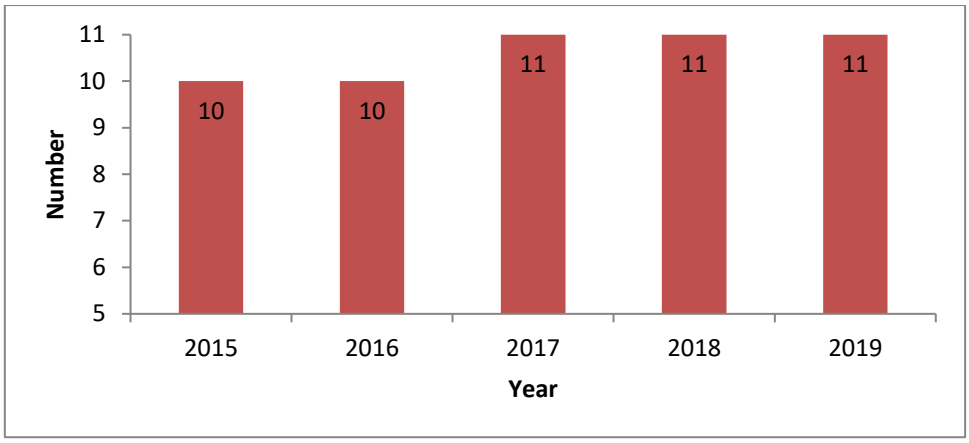


Table A5-24: Number of districts with evidence based annual health plans

Year	2015	2016	2017	2018	2019
No. districts with facilities	10	10	11	11	11

Figure A5-21: Number of districts with evidence-based annual health plans



Facility assessment

Table A5-25: Type of services that received support from the Afya Bora Project

	TYPE OF SERVICE								
Facility	BEmONC	CEmONC	ANC	ENC	KMC	FP	Nutrition_services	WASH	YFSs
Fuoni PHCU+	1	0	0	0	2	1	1	0	2
Kivunge District Hospital	1	1	1	1	1	1	0	0	1
Nungwi PHCU+	2	0	1	1	0	1	1	2	0
Mnazi mmoja	1	1	1	1	1	0	0	0	0
Wete	1	1	0	1	2	0	0	2	2
Kengeja	2	2	2	2	2	2	2	2	0
Junguni PHCU+	1	1	1	1	0	1	0	2	0
Total HFs receiving a service (1)	**5**	**4**	**4**	**5**	**2**	**4**	**2**	**0**	**1**

0=No 1=Yes 2=I don't know

Table A5-26: Currently assigned staff to RMNCAH and nutrition services (n=187)

	MD	OBGY	Nurse/Midwife	AMO	CO	Lab tech	Pharmacist	Anesthetist	Ultrasound	Total
Fuoni PHCU+	0	0	18	1	5	3	2	0	0	29
Kivunge District Hospital	7	0	10	1	0	7	5	5	0	35
Nungwi PHCU+	0	0	2	0	0	1	0	0	0	3
Mnazi mmoja Hospital	16	4	41	0	0	0	7	14	0	82
Wete	4	1	12	1	2	0	0	0	0	20
Kengeja	0		2	0	1	2	1	0	0	6
Junguni PHCU+	0	0	5	1	2	2	1	0	1	12

Figure A5-22: Currently assigned staff to RMNCAH and nutrition services

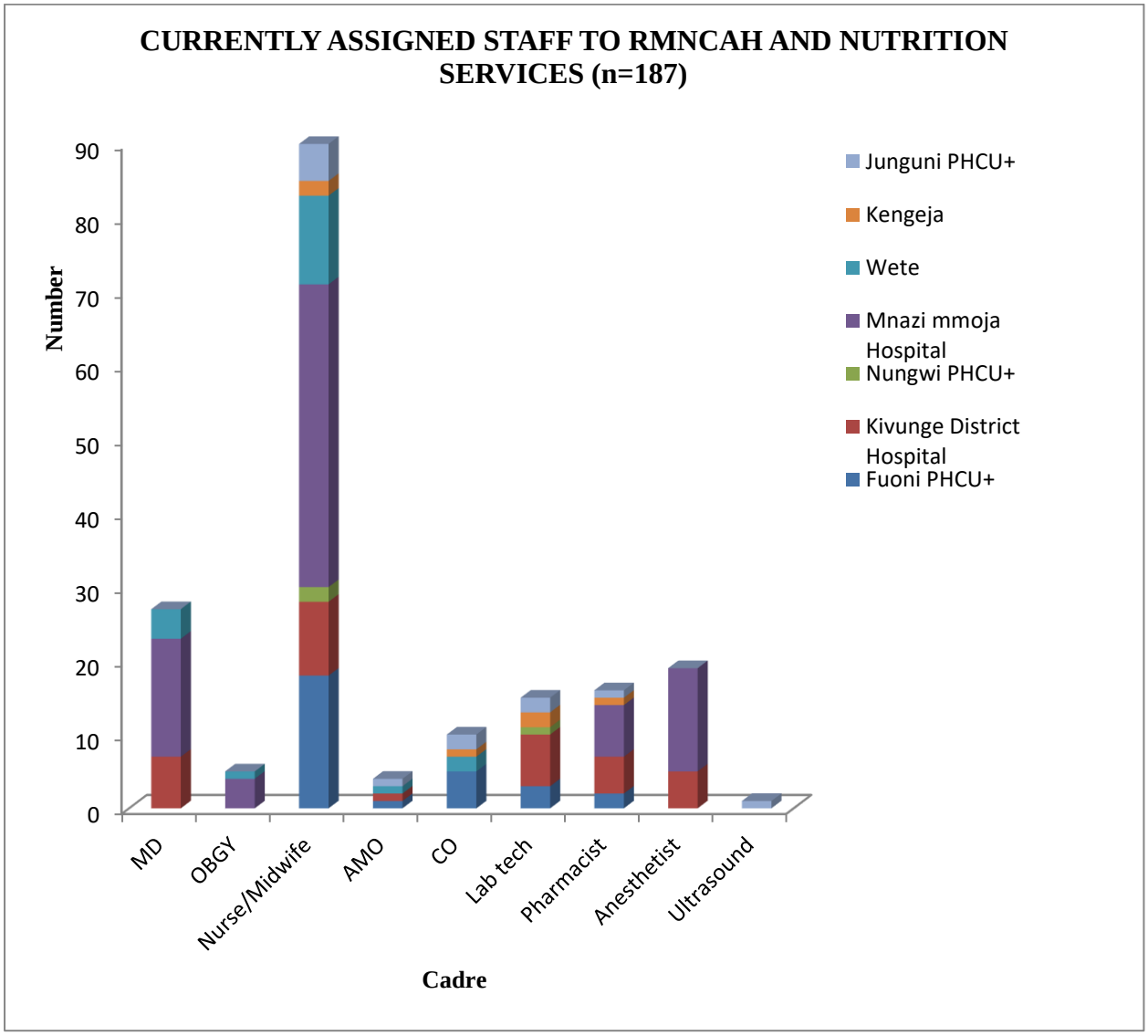


Figure A5-23: Proportion of staff working in RMNCAH and Nutrition services

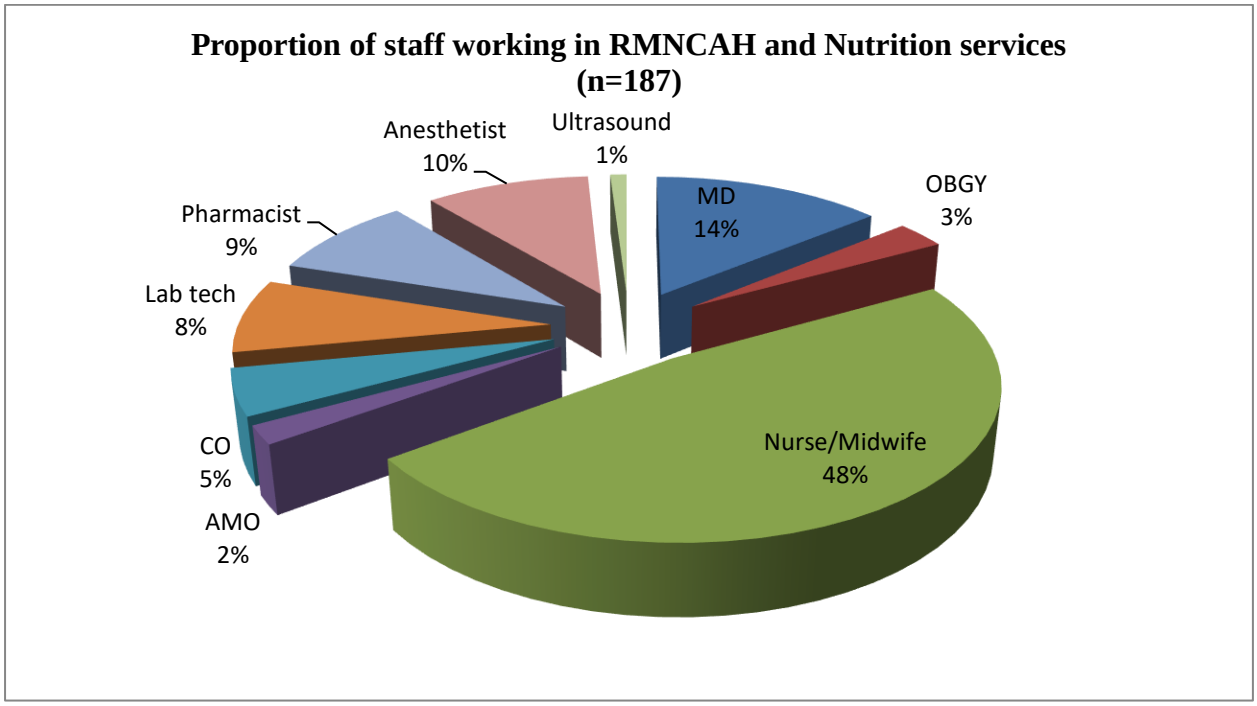
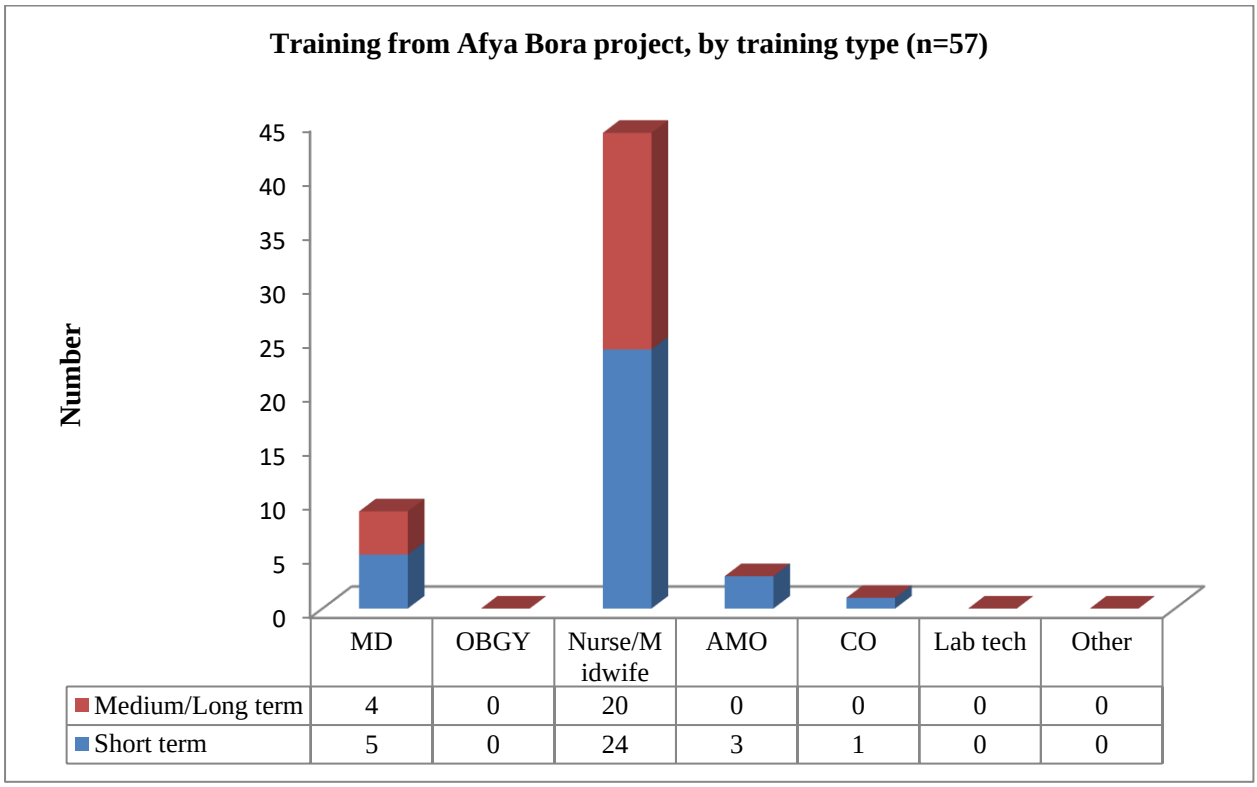


Figure A5-24: Training from Afya Bora project, by training type



	MD	OBGY	Nurse/Midwife	AMO	CO	Lab tech	Other
Medium/Long term	4	0	20	0	0	0	0
Short term	5	0	24	3	1	0	0

Figure A5-25: Training from Afya Bora project on the following technical areas by sex (n=64)

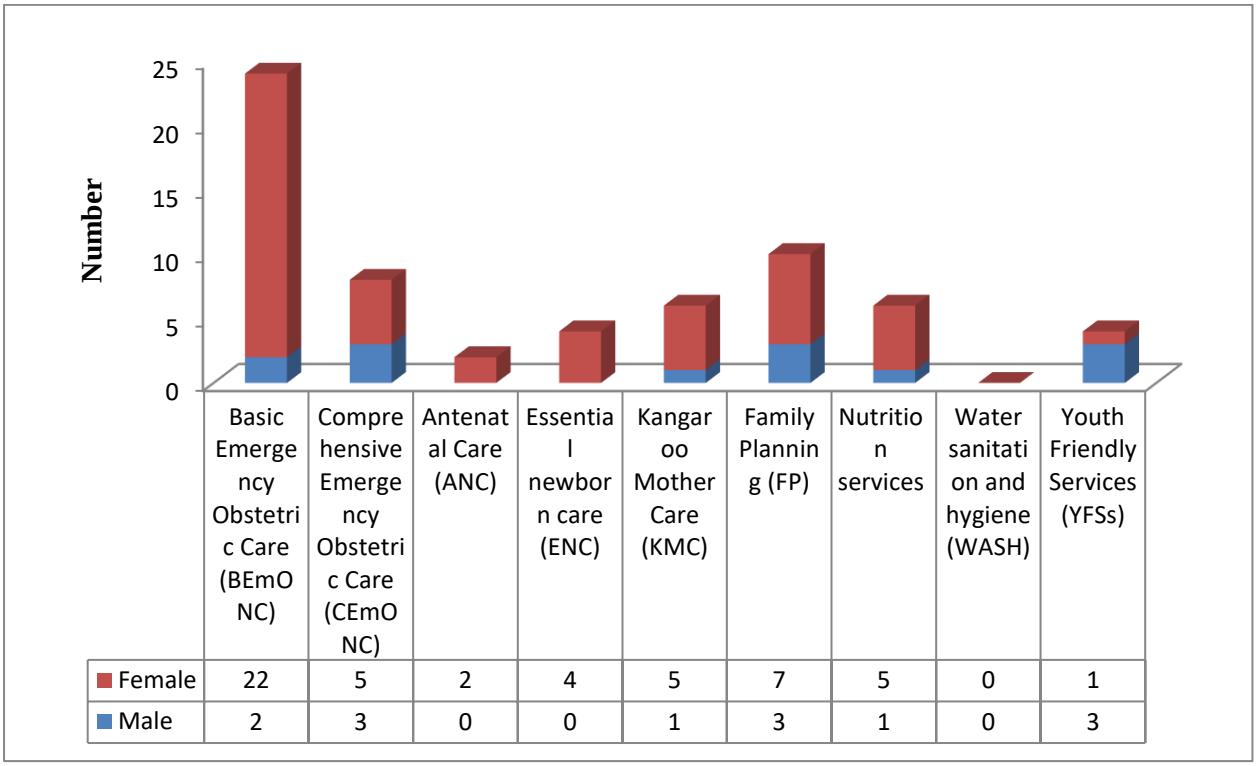


Table A5-27: Youth-friendly services

	Fuoni PHCU+	Kivunge District Hospital	Mnazi Mmoja Hospital	Nungwi PHCU+	Wete	Kengeja	Junguni PHCU+
Offer Youth-friendly services (YFSs)	1	1	0	1	0	0	0
Designated space at the facility for providing YFSs	0	0	2	1	0	0	0
Designated/specified days and/or hours for young people to receive sexual and reproductive health services	0	0	2	0	0	0	0
2.4 Are there IEC materials	0	0	0	0	0	0	0

0=No

1=Yes

2=I don't know

Table A5-28: Services provided to adolescents and young people per facility

	Fuoni PHCU+	Kivunge District Hospital	Mnazi Mmoja Hospital	Nungwi PHCU+	Wete	Kengeja	Junguni PHCU+	Total
Education and/or counseling on SRH	1	0	0	1	0	0	0	2
Male condoms	1	1	0	1	0	0	0	3
Female condoms	0	0	0	1	0	0	0	1
Oral contraceptive pills	1	0	0	1	0	0	0	2
Emergency contraception pills	2	0	0	1	0	0	0	1
Other Contraceptive methods (Injectable, IUDs, Implants)	1	0	0	1	0	0	0	2
ANC for AGYW	1	0	0	1	0	0	0	2
Labour and delivery services for AGYW	1	0	1	1	0	0	0	3
STI screening and treatment	1	0	0	1	0	0	2	2
HIV counseling and testing	1	0	0	1	0	0	0	2

0=No

1=Yes

2=I don't know

In the white field

Figure A5-26: Services provided to adolescents and young people per facility

Table A5-29: Number of facilities by type of youth-friendly services provided

Type of service	Total No. Facilities
Education and/or counseling on SRH	2
Male condoms	3
Female condoms	1
Oral contraceptive pills	2
Emergency contraception pills	1
Other Contraceptive methods (Injectable, IUDs, Implants)	2
ANC for AGYW	2
Labour and delivery services for AGYW	3
STI screening and treatment	2
HIV counseling and testing	2

Figure A5-27: Number of facilities per service

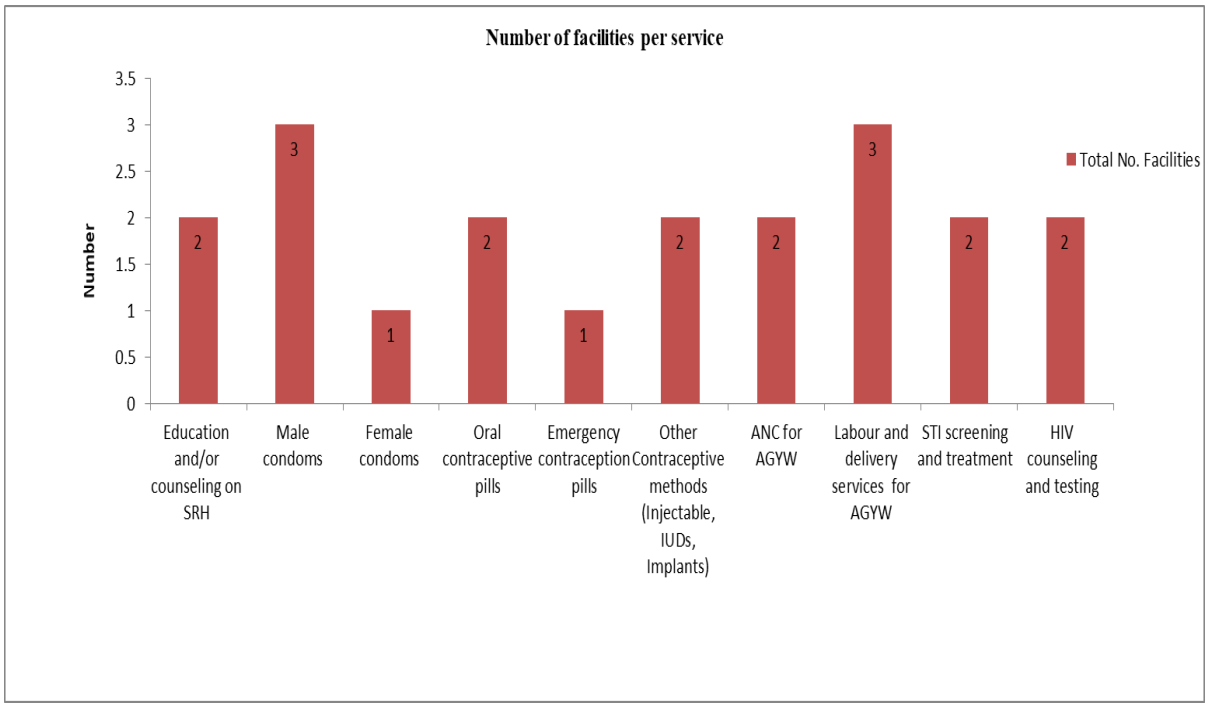


Table A5-30: Equipment and Supplies

All facilities receive equipments for RMNCAH from Afya Bora Project

Facility	Equipments received
Fuoni PHCU+	1. Beds-7 (for antenatal and postnatal) 2. Delivery bed (1) 3. Incubation machine 4. Delivery kits 5. Furniture (tables, cupboards, and chairs) *6.* Equipment Trolleys screen (1).
Kivunge District Hospital	1. Theatre bed 2. Examination torch-4 3. Drip stand-many 4. Delivery sets 5. Delivery bed-2
Mnazi Mmoja Hospital	1. Delivery sets- 20 2. TV screens-3 3. KMC equipment: Hb Machine, Glucometer, 4. Office table-1 and chairs-2 5. Electronic weighing machine for neonates 6. Pulse oxymeter 7. Waiting benches
Nugwi	Speculum
Junguni PHCU+	1. Tables 2 2. Chairs 4 3. Hospital beds 3 4. Delivery beds 2 5. Bedsheets 5 6. Curtains 3 7. Baby warmer 1 8. Delivery kits 10
Wete	Cot beds Delivery kits

- When asked if they have enough equipment needed to provide RMNCAH services all responded no except Junguni PHCU+ said Yes
- Fuoni, Junguni PHCU+, Kengeja, Wete and Kivunge District Hospital didn't receive supplies for RMNCAH from Afya Bora Project, while Nungwi didn't know if they received or not and only MMH received supplies.
- Fuoni PHCU+, Junguni PHCU+, Kengeja PHCU+ and MMH didn't experience stock- out of any RMNCAH commodities in the past 12 months (1 December 2018 to 30 November 2019).
- Kivunge District Hospital had a stock-out of RMNCAH commodities in the past 12 months (1 December 2018 to 30 November 2019Dexamethasone injection (for 2 months)Fefol (for 2 months))
- Nungwi PHCU+ also had experienced stock-out of the following; Misoprostol (2 months), Oxytocin (20 days), Ferrous sulphate (for over 2 months), Mebendazole (for over 3 months)

REFERRAL SYSTEMS

Clear referral system

- Fuoni PHCU+, Nungwi, MMH and Kivunge District Hospital had clear referral system for pregnant women, mother and children under 5 years
- Junguni PHCU+ had no clear referral system for pregnant women, mother and children under 5 years
- Kengeja and Wete didn't know if they had a clear

Ambulance assigned for emergency referral

- Four facilities had ambulance assigned for emergency referral (Fuoni 1, Kivunge 1, Junguni PHCU+ and Mnazi mmoja)
- Nungwi, Kengeja and Wete had no ambulance assigned for emergency referral
- Kengeja and Wete didn't know if they had ambulance assigned for emergency referral or not

Availability of Community Health Volunteers (CHVs)

Five facilities (Fuoni, Kivunge, Kengeja, Junguni PHCU+ and Nungwi) had Community Health Volunteers (CHVs) facilitating referrals from the catchment area

Mnazi mmoja and Wete had No CHVs

Success made from CHVs

- When asked if CHVs have successfully made referrals of pregnant women, mothers and children to the facility three facilities (Fuoni, Kivunge and Nungwi) responded yes
- MMH didn't know if there was any success.
- Kengeja didn't experience success with CHVs
- Junguni didn't have CHVs PHCU+

System for referrals documentation for mothers and children

All facilities had no system to documents referrals for mothers and children except Kengeja

Referral cases received

Maternal referral cases

- In 2018 Kivunge District Hospital reported 71 maternal referral cases while Fuoni had none. In 2019 both reported 14 maternal referral cases
- In 2018 and 2019 Junguni PHCU+ had 6 and 14 maternal referral cases respectively.

Newborn referral cases

Fuoni and Kivunge each had 3 children (under 5) referral cases in 2018

Table A5-31: RMNCAH infrastructure

	Infrastructure support	BEmONC	Youth-Friendly Services	Incinerators	Placenta pit:
Pemba	**Junguni PHCU+**	1	0	0	1
	Uondwe PHCU+	1	0	0	1
	Bogoa PHCU+	1	0	0	1
	Bwagamoyo PHCU	0	1	0	0
	Mbuzini PHCU	0	1	0	0
	Micheweni District Hospital	0	0	1	0
	Wete District Hospital	0	0	1	0
Unguja	**Fuoni PHCU+**	1	0	0	1
	Tumbatu PHCU+	1	0	0	1
	Sebuleni PHCU+	1	0	0	1
	Mwela PHCU	0	1	0	0
	Suza Uni	0	1	0	0
	Nungwi PHCU+	0	1	0	1
	Bwejuu PHCU	0	1	0	0
	Uzini PHCU+	0	0	0	1
	Mfenesini PHCU+	0	0	0	1
	Selemu PHCU	0	0	0	1
	Total	**6**	**6**	**2**	**10**

1=done 0=Not done

Type of Policy/Strategy

- Kivunge and Nungwi had RMNCAH policies/Strategies/ Guidelines
- **Fuoni PHCU+** and Kivunge had Nutrition policies/Strategies/ Guidelines/ Protocol/ Job aides
- **Nungwi PHCU+** had RMNCAH (FP, ANC) policies/Strategies/ Guidelines/ Protocol/ Job aides and WASH IPC job aids
- **Kivunge reported** to have other policy
- **Mnazi Mmoja Hospital** had the following:
    - Guideline (Pre-eclampsia and eclampsia (H.B.S), Essential care for small babies (H.B.S), Essential care for everybody (H.B.S))
    - Ministry of Health Main-land (Hospital Management Quality Care)

- Ministry of Health Zanzibar (Standard Treatment Guideline
- Zanzibar National Guideline for the prevention and treatment and AIDS
- Essential Newborn Care (Trainees Manual-2016)
- Essential Newborn Care (Chart booklet)

- **Junguni PHCU+** had RMNCAH policies/Strategies/ Guidelines/ Protocol/ Job aides (PMTCT, vaccination, malaria), WASH policies/Strategies/ Guidelines/ Protocol/ Job aides (IPC guideline, job aid for hand washing)
- **Kengeja** had no policies/Strategies/ Guidelines/ Protocol/ Job aides
- **Wete** had IPC guideline, job aid for hand washing

Table A5-32: List of equipments (from RCH distribution list)

Dissection kit	Scissor Stich removing 15cm, Forceps Sponge Holding straight 20cm, Tray Instrument Stainless steel 22.5x12.5x5cm with cover, Pair scissors bandage lister angular 18cm , Jar Forceps pp 180mm with cover
Furniture	Bed Hospital Standard with Mattress, Wheel chair, Adult Foldable, Bed Labour delivery with accessories, Examination table
Maternal examination	Weighing Scale, Infant, Beam type 16kgx10g, Light Examination mobile
Resuscitator	Ambu Bag Adult, Ambu Bag new born, Oxygen Concentrator Resuscitator
Fetalscope	Doppler Fetale, Stethoscope Binaural, Stethoscope foet bal pinard aluminum 000021
Trolley	Dressing Trolley, stainless steel 2Trays, Emergency Trolley with drawers
Utensils	Basin Kidney stainless steel 825 ml, Galipot stainless still 150ml, Basin Kidney plolypropylene 475 ml, dressing tray stainless steel 30x22x3 cm
Sterilizer	Forceps Sterilizer cheatle Curved 27cm, Sterilizer Pressure cooker 320X320mm 24 litters, Autoclave Horizontal Table-top 40L
Delivery kits	Midwifery Kit-2 Equipment, Midwifery Kit-3 Renewable
Baby warmer electronic	
Bedpan polypropylene Adult	
Sanction Pump Foot/Hand Operated 600 ml (twin)	
Sphygnomanometor Android Adult	

TRAININGS

Table A5-33: Short term training n=1090

Training	Number of HCWs Trained
IMCI	460
Essential Newborn Care	350
BEmONC	200
Youth Friendly Services	55
Nutrition/Growth monitoring	25
Total	**1090**

Figure A5-28: Short term trainings (less than 3 months), n=1,090

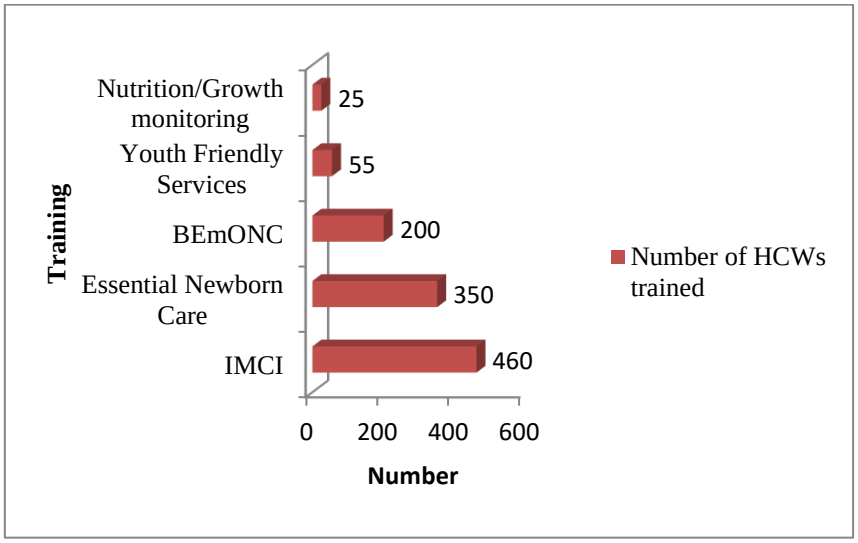


Table A5-34: Advanced training (n=42)

Type of Training	Male	Female	Total
MMED OBGY	1	4	5
MSc. Midwifery	0	7	7
MMED Anesthesiology	0	1	1
Anesthesia officers	3	3	6
MSc. Pediatric Nursing	0	1	1
MSc. Critical Care and Trauma	0	1	1
Masters M&E	0	1	1
MPH	1	0	1
Advanced diploma (AMO)	7	3	10
CEmONC **(**Nurse/Midwives)	3	6	9
Total	15	27	42

NB: CEmONC (Nurse/Midwives) had mid-term training

Figure A5-29: Advanced Training

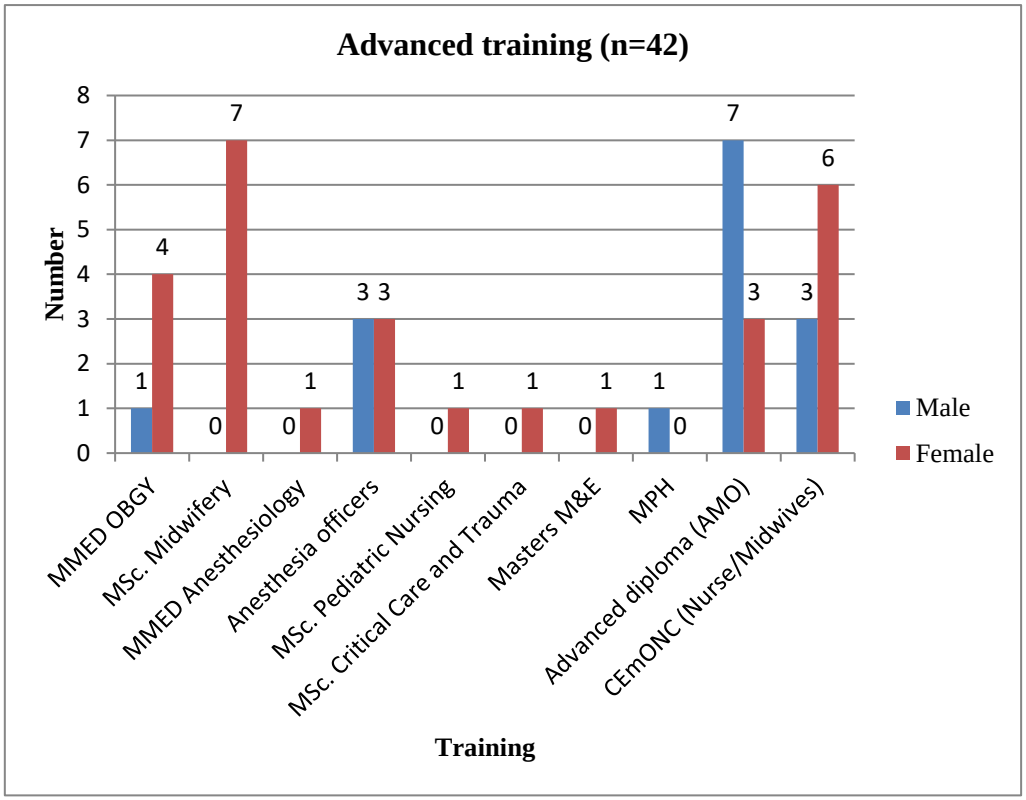


Table A5-36: Total HCWs Trained (n=42)

Sex	Proportion
Male	12 (29%)
Female	30 (71%)

Figure A5-30: Training attendance by sex

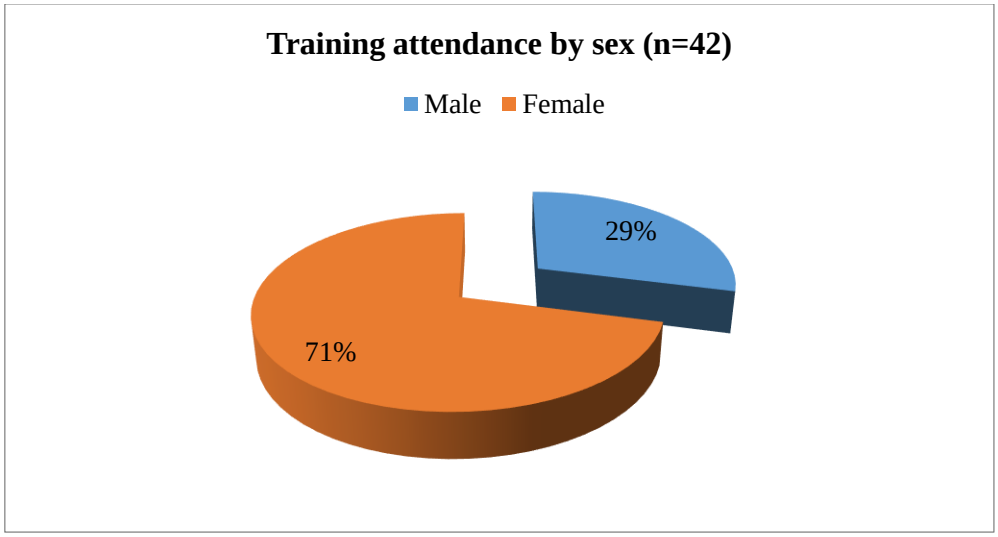


Figure A5-31: Retention to the work station after training, n=42

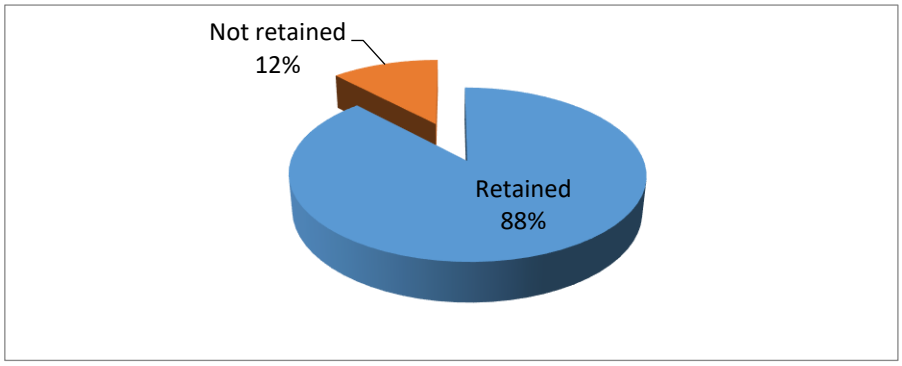


Figure A5-32: Retention to the work station after training, n=42

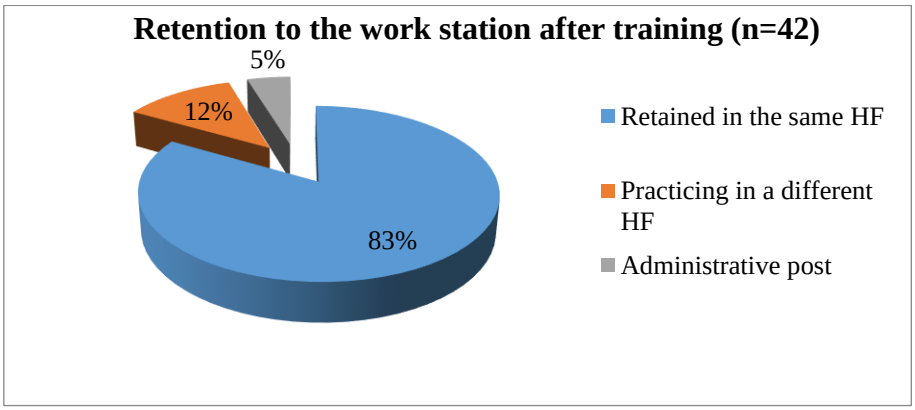


Table A5-37: All healthcare workers trained (n=1132)

Duration	Training	Number
Short term	IMCI	460
	Essential Newborn Care	350
	BEmONC	200
	Youth Friendly Services	55
	Nutrition/Growth monitoring	25
	Subtotal	1090
Advanced trainings	Advanced diploma (AMO/CEmONC)	10
	MMed. OBGY	5
	MSc. Midwifery	7
	MMed Anesthesiology	1
	Anesthesia officers	6
	MSc. Pediatric Nursing	1
	MSc. Critical Care and Trauma	1
	M&E	1
	MPH	1
	CEmONC (Nurse/Midwives)	9
	Subtotal	42
	Total	1132

NB: CEmONC (Nurse/Midwives) had mid-term training

Annex 6: List of Persons Interviewed

National

Name	Position	Organisation
Sharifa Awadh	Focal person of Life Saving Commodities	MoHZ- IRCHP
Asha Mfaume	Administrator	MoHZ- IRCHP
Dr. Maryam J. Bakari	Coordinator, Child Health (IMCI)	MoHZ- IRCHP
Khadija Said Simai	Chief Planning Officer	MoHZ
Khadija Khamis Kasi	Head-Training Unit	MoHZ
Fredrick Makanyaga	HMIS Focal Person	MoHZ
Mr Kidua	ibid	ZNBTS
Bi Amina	Dean	College of Health Sciences
Dr. Maha Damaj	Chief of Zanzibar Field Office	UNICEF Tanzania
Ramadhani Noor	Health Specialist, Zanzibar Field Office	UNICEF Tanzania
Batula Hassan Abdi	Programme Specialist , Reproductive Health	UNFPA Tanzania
Azzah Nofly	Programme Analyst, SRH/HIV	UNFPA Tanzania
Asma Khamis	Programme Manager	Save the Children
Mauro Brero	Chief Nutrition	UNICEF Tanzania

District Name: Kaskazini (North) A

Name	Position	Organisation
Mwanaali Haji Ali	District Public Health Nursing officer(DPHNO	CHMT member
Menge Hassan Menge	District Health Administrator	CHMT member
Khadija Ally Makame	District HPU focal person	CHMT co-opted member
Khadija Hussein Uledi	District Nutrition focal person	CHMT co-opted member
Dr. Himid Juma Saidi	Assistant Director Preventive services and Health education (DMO)	CHMT member

District Name: Magharibi B

Name	Position	Organisation
Sharifa Abdullah Seif	District Data Manager	CHMT Member
Sabiha Makame Khamis	District Health Administrator	CHMT Member
Mwanamvua Mussa Bilal	District Public Health Nursing officer (DRCHCo)	CHMT Member
ibid	District Pharmacist	CHMT Member
Amina Sleyyum Addi	District health promotion officer	CHMT co-opted member
Mwanahija Kombo Mbarouk	Ag. District Nutrition focal person	CHMT co-opted member
Leyla Salum	Assistant Director for health services	Municipal of Magharibi B

District names: Wete and Mkoani

Name	Position	Organisation
Juma Suleiman Hassan	Administrator	CHMT Mkoani
Moza Mohid Ali	District Public Health Nursing Officer (DPHNO)	CHMT Mkoani
Hamad Said Hassan	DPHR	CHMT- Wete
Rahima Issa Omar	District Public Health Nursing Officer (DPHNO)	CHMT- Wete
Sabiha Khalfan Said	DNFP	CHMT- Wete
Ali Said Mussa	Administrator	CHMT- Wete
Faki Hammad Faki	IMIPANGO	CHMT- Wete
Raya Mkoko Hassa	N. Coordinator	Pemba
Sabra Salim Suleiman	Matron	Wete District Hospital
Khamis Rashid Salim	Medical Officer In-charge	Wete Hospital

Annex 7: Evaluators Biodata

Team Leader and Evaluation Expert – Ngonidzashe Marimo

Ngoni is an expert evaluator with 15 years' experience in evaluation. He holds a Masters in Poverty and Development from the University of Sussex, Institute of Development Studies. He has extensive in Eastern and Southern Africa including Tanzania. He has extensive experience leading small and complex evaluations in the region including United National Joint programmes and bilateral donors' country and regional strategies. Some of the reports he has written have received global recognition[29] and been rated "satisfactory" and "highly satisfactory" in the UNICEF GEROS system[30]. Ngoni has strong qualitative and quantitative evaluation and research methods having led numerous evaluations that extensively used mixed methods. Recently, January 2019, Ngoni completed evaluation of the UNICEF WASH in Schools Project which combined quantitative survey (structured questionnaires, observations and secondary data checklists) and qualitative methods (key informant interviews, focus group discussions and case studies). In 2017 Ngoni led a national evaluation of the Kenya Drought Response using cash transfers. The evaluation included a national survey combined with qualitative interviews. In Tanzania participated in the evaluation of the UNICEF 7 Learning Districts Project. He has also led impact evaluations: including impact evaluation of Adolescent Sexual and Reproductive Health Interventions in Zimbabwe; impact assessment of the HORIZONT300's Technical Assistance (TA) Programme in Eastern and Southern Africa and participated in the impact evaluation of the Malawi Social Action Fund. Ngoni has extensive experience in using theories of change and undertaking theory based evaluations for UNICEF and other UN projects in Eastern and Southern Africa. Ngoni developed the first Gender Equality and Women's Empowerment Monitoring and Evaluation system for the government of Zimbabwe and participated in the development the Results Based Monitoring and Evaluation system linked to planning for the Mozambique Government.

Ngoni has extensive experience in the health and nutrition sectors having evaluated projects and facilitated development of strategies and operational plans. He was part of the core team for the first nationwide Zimbabwe National Health Facility Assessment survey for RMNCAH services. He was the national team leader for a three impact assessment of DFID's programme accountability in health which sought to strengthen communities' ability to demand better RMNCAH service delivery from health facilities. Ngoni also led a baseline for the Urban Component of Health Results-Based Financing Project which sought to improve RMNCAH service delivery as well as accessibility and utilisation of the services. In 2015, he evaluated two RMNCAH focused projects for Plan International and CARE in Zimbabwe. In 2012, Ngoni led KABP survey on nutrition for World Vision, while in 2017 he was team leader for a food security and nutrition project evaluation for SNV.

Ngoni is very adept of human rights based approaches, equity and gender issues as evidenced by one of the evaluation reports being used as examples of good practices for mainstreaming gender in evaluation for the UN Evaluation Group (UNEG) publication on, "Good practices for Integrating Gender Equality and Human Rights in Evaluation". Ngoni has excellent spoken and written English and impeccable communication skills.

Contact: ngoni@developmentsolutions.co.zw; info@developmentsolutions.co.zw

RMNCAH Services Expert: Dr Dunstan Bishanga

Dr. Dunstan Bishanga, a thought leader and PMD Pro–certified public health systems management expert and research scientist, has over 10 years of specialized service delivery and management experience managing and implementing large-scale, integrated health projects, studies and

[29] https://gate.unwomen.org/Evaluation/Details?EvaluationId=4811

[30] https://www.unicef.org/evaldatabase/index_94229.html and End of Project Evaluation of WASH in Schools Project in Zimbabwe.

operations. He holds a PhD in Safe Motherhood focusing on quality of care from the Groningen University, Graduate school of medical sciences in the Netherlands. He also holds a Masters of Science in Health Informatics with Public Health and a Doctor of Medicine degree from the University of Dar es salaam. Dr. Bishanga is a senior consultant in public health with practical experience in program design and proposal writing, execution and evaluation of complex health programs in Maternal, Newborn, and Child health, Sexual and Reproductive health, Nutrition, Malaria, Gender, Adolescents and Youths, and integration with HIV/AIDS programs. Dr. Bishanga has served in the capacity of Director of Maternal, Newborn and Child Health programs for Jhpiego Tanzania, while also serving as a Chief of party for a USAID-funded USAID Boresha Afya, focusing on improving RMNCAH, Malaria and Nutrition in 7 regions of mainland Tanzania, with a total value of over $59mil for five years. He led a team of over 120 staff of various cultural and professional background across six offices to design, implement, monitor and evaluate high impact interventions.

Previously at Jhpiego, Dr. Bishanga worked as a Chief of Party for two other USAID flagship programs in reproductive, maternal, and newborn health (RMNH) in Tanzania, namely the MCSP and MAISHA programs. Before joining Jhpiego, Dunstan led successful public health programs at other international organizations, including EngenderHealth, Marie Stopes International, and Family Health International (now FHI360).

Dr. Bishanga has extensive experience working in Tanzania, both mainland and Zanzibar, and collaborating with key stakeholders, including local communities and CBOs, the host-country government and its agencies at the national and local levels, UN agencies, donor agencies (European Union, DFID, Children Investment Fund (CIFF), Global Affairs Canada, Global Fund), and international as well as local non-governmental organizations.

Dr. Bishanga has more than 10 years of experience in conducting human subjects research including as a principal investigator for studies approved by Institutional Review Boards (IRB) both at Johns Hopkins University and the Tanzania National Institute for Medical Research (NIMR). He has been involved in research design, implementation, data analysis, presentation, and publication related to various topics of public health importance, including maternal and newborn health, family planning, HIV/AIDS, digital health (ICT4D), and gender and male involvement in reproductive health. He has contributed to over 14 scientific peer-reviewed publications including as a lead author.
Contact: info@developmentsolutions.co.zw

Health Policy and Systems Expert: Dr Mapunda, Pasiens Stephen

Dr Mapunda is a Public Health Practitioner who specialized in public health and tropical medicine at Leeds and Liverpool Universities in UK respectively. He also holda a Master's degree in International Community economic development from the University of Southern New Hampshire (SNHU), USA. He has 27 years of experience in implementing and evaluating RMNCAH, nutrition, health and other similar programmes and health services. Dr Mapunda has been the Director of a UNFPA funded MCH/ Family planning (MCH/FP/) Safe Motherhood Program in Zanzibar – a position he served for seven years (1991-1998). During the first 6 years, he was seconded to the Ministry of Health, responsible for vision, planning, strategy and overall project management. In the last year 1997 – 1998 he was Project Technical Adviser-Safe Motherhood Program, responsible for program development, monitoring implementation, capacity strengthening, supervision of financial and material resources management. Dr Mapunda later joined the British Council in the capacity of a health and population sector specialist in 1998, the USAID mission in Tanzania as a project Management specialist in 2000. He worked as a Center Director of the Centre for enhancement of effective Malaria interventions at the National Institute for medical research (NIMR) 2004-2009, Dr. Mapunda joined Pathfinder International in 2009. He worked with the organization in the capacity of a Deputy Country representative for 7 years. Thereafter, he took a teaching post at a private University in Dar, Tanzania in the year 2016. . Over the years, he has accumulated across the board experience at senior levels

through working with the government Ministry of Health in Tanzania as a District Medical Officer, UNFPA, The British Council, USAID, International American based NGO, Pathfinder International, a local NGO and currently a senior lecturer at Hubert Kairuki Memorial University, in Mikocheni Dar-es-Salaam. His professional areas of interest and experience include Maternal, child health and family planning advocacy, health program management, monitoring and evaluation, population dynamics, social accountability and community economic development. Through extensive experience in health research, he has also accumulated excellent skills and experience in facilitating KII, FGDs with various groups of stakeholders. Dr Mapunda's wide experience in working with human rights based development actors like the USAID and UNFPA guarantees his familiarity with the social and human rights based approach, equity and gender issues.

Contact: info@developmentsolutions.co.zw

Annex 8: Tools and Consent Forms

Separate attachments

Annex 9: Results of the Evaluability Assessment

Original indicator	Potential data source	Action/Remarks
Number of youths utilized SRH/FP services	HMIS/DHIS2 Routine disaggregated data	Rephrased to: Number of youths receiving YFSs by type (education, counselling, FP counselling, FP acceptance, STI management; ANC services; PAC)
Proportion of health facilities with at least two health providers who have received training on distance learning IMCI and Essential New-born Care	Training reports; Annual reports	The MOHZ and project partners to compile a list of staff per facility as of October 2019, by training status (in project's focus areas)
Proportion of health facilities conducting maternal and perinatal death reviews	RCH-IMCI focal person	Adopt the current indicators in HMIS: • Proportion of notified maternal deaths that are reviewed • Proportion of notified perinatal deaths that are reviewed
Proportion of HFs receiving 4 integrated RMNCAH supportive supervision visits per year	Monitoring reports (integrated RCH program)	The IRCHP to share a list of supportive supervision visits made per facility per year
Number of districts with evidence based plans	M&E and/or Planning Unit reports	The MOHZ to share a list of "approved" list of districts with evidence-based plans per year
Proportion of skilled health care workers for RMNCAH services (% increased)	Staffing and training reports/RCH	Rephrase the indicator to: Number and % increase in the number of HCWs trained in RMCAH. Depends on availability of training reports over the project's duration
Number of Shehias reporting on community health volunteers activities per year	Health promotion unit (HPU)/Project partners report	Consider: Shehias that submitted at least 75% of expected reports in a year. Receive compiled performance list from the MOHZ
Number of pregnant women, caregivers of children under 5 years old and adolescents participating in promotional RMNCAH, WASH and nutrition services per year	Health promotion unit (HPU)/Annual reports;	Compiled number of audience reached with promotional activities annually
Number of Health Care Professionals retained (following mid-term and long-term trainings)	Training and staffing reports, Annual reports	Rephrase to: Number of Health Care Professionals retained in their positions following supported mid-term and long-term trainings Consider:

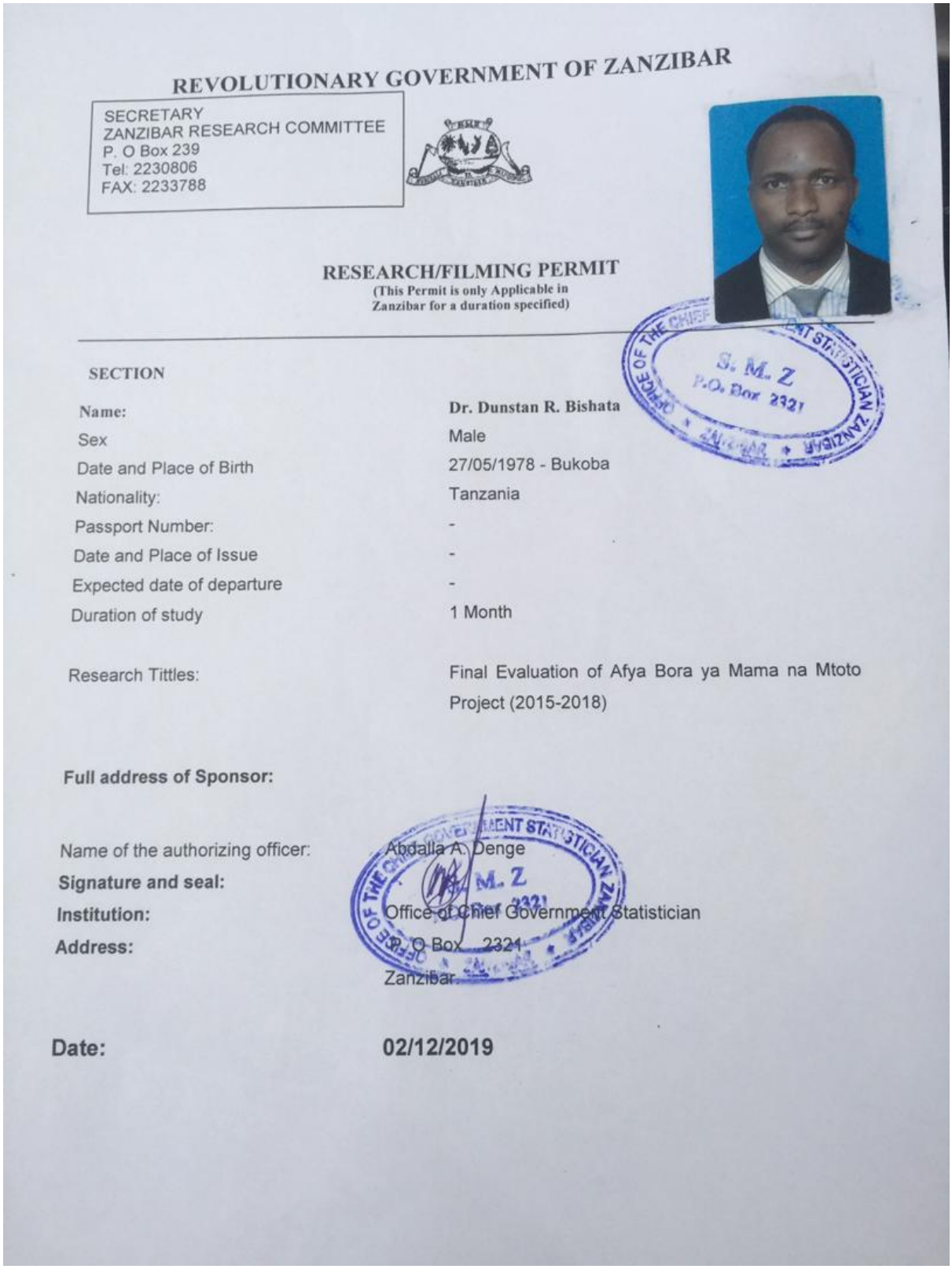
Original indicator	Potential data source	Action/Remarks
		Total HCWs trained per facility over life of project Total HCWs still working in project sites
Number of students reached by teachers with RMNCAH, WASH and nutrition messages per year	Health promotion unit (HPU)/Annual reports;	Availability of compiled school program reports
Number of persons reached with radio spots on RMNCAH, WASH and nutrition messages per year	Media reports; Project annual reports	Availability of Mass media reach reports over life of the project

Based on this assessment the table below represents the full list of quantitative indicators with available data to be incorporated in the evaluation.

Indicators/variables	Data source/Type of reports	Baseline/Endline
Proportion of pregnant women making 4 ANC visits	HMIS/DHIS2 Routine reports	2015/2019
Number and proportion of children (0-59 months) with severe acute malnutrition treated by OTC (outpatient therapeutic care) and ITC (inpatient therapeutic care)	HMIS/DHIS2 Routine reports	Yearly (trends)
Proportion of facilities without stock out of supply throughout a year	eLMIS reports (LMU)	2015/2019
Caesarean section rate	HMIS/DHIS2 Routine reports	2015/2019
Facility-based deliveries (in supported HFs)	HMIS/DHIS2 Routine reports	2015/2019
Proportion of HFs with star rating of 3 and above	Accreditation Reports (Health Sector secretariat)	2015/2019
Functional Blood Bank freezer and refrigerator	ZNBTS inventory/ physical assessment	Cross-sectional on day of visit
Number of blood donation sensitization activities per year	ZNBTS reports	Yearly
No. of ambulances procured/maintained	Functional Ambulance reports; Hand over Memo	Cumulative
Equipment and Supplies procured	Procurement and distribution reports	Cumulative
Infrastructure improvement • Number of EmONC sites refurbished • Number of YFSs refurbished	Refurbishment reports, Physical verification	Cumulative
Proportion and number of health facilities with at least one health worker trained to	Training reports; Annual reports	Cumulative

Indicators/variables	Data source/Type of reports	Baseline/Endline
provide promotional RMNCAH, WASH and Nutrition services		
Proportion and Number of Shehias with at least one community health volunteer trained to provide promotional RMNCAH, WASH and Nutrition services • What proportion are still active?	Training reports; Annual reports. (also MOHZ reports)	Cumulative; latest CHVs report
Number of six-monthly (semi-annual) monitoring/reviewing meetings at Zonal level organized every year	Meetings reports per MOHZ sections; Annual reports	Annually
Infrastructure improvement • Number of EmONC sites refurbished • Number of YFSs refurbished	Refurbishment reports	Cumulative
Availability of Youth Friendly Services	Facility visit: YFSs reports and structured observation	July-Sept 2019 service statistics; day of visit observation
Availability of RMNCAH equipment and Supplies	Facility visit: Quarterly inventory and supply chain reports	July-September 2019 stock out reports
Availability of trained HCWs in RMNCAH, YFSs and Nutrition	Facility visit: Staffing list and training reports; Key informants	Cross-sectional
Availability of life saving services for mothers and new-borns (EmONC, KMC, care of the New-born)	Facility visit: Aggregate service statistics reports; physical space (readiness)	July-September 2019 services summary reports
Availability of functional referral system	Facility visit: Referral filing and reporting system	July-September 2019
Improved infrastructure	Facility visit: Functional incinerators, placenta pit, Labour ward, Theatre (for CEmONC)	Cross-sectional

Annex 10: Ethical Clearance Certificate



REVOLUTIONARY GOVERNMENT OF ZANZIBAR

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RESEARCH/FILMING PERMIT
(This Permit is only Applicable in Zanzibar for a duration specified)

SECTION

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Duration of study	1 Month
Research Tittles:	Final Evaluation of Afya Bora ya Mama na Mtoto Project (2015-2018)
Full address of Sponsor:	
Name of the authorizing officer:	Abdalla A. Denge
Signature and seal:	
Institution:	Office of Chief Government Statistician
Address:	P. O Box 2321 Zanzibar.

Date: **02/12/2019**