

# Maternal and new-born child health Final Evaluation

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## Final Report

Submitted to:

**Comic Relief**

Submitted by:

**Policy Research Institute, Sarl (PRI)**

Date:

**May 20, 2021**



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## Disclosure Statement:

The views and opinions expressed in this document are those of the authors and do not necessarily reflect the official policy or position of the client, Comic Relief, National Lottery Community Fund or their partners - Makerere University School of Public Health, Doctors with Africa CUAMM, and Women and Children First, UK.



## TABLE OF CONTENTS

Acronyms.....	v
Definition of Key terms .....	vii
Acknowledgements .....	viii
Executive Summary .....	ix
1. Introduction and Background.....	1
1.1 Introduction .....	1
1.2 Programme Description.....	1
1.3 The context.....	3
1.4 Evaluation purpose and objectives .....	5
1.5 Evaluation questions .....	5
2. Methodology.....	6
2.1 Overall approach.....	6
2.2 Data collection instruments .....	6
2.4 Approach to data analysis .....	7
2.5 Ethics and participation.....	7
2.6 Limitations and challenges .....	8
3. Findings .....	8
3.1 Programme Impact on infant mortality and stillbirths .....	8
3.2 Most successful strategies in implementation of pre and postnatal care practices .....	12
3.3 Effectiveness of PLA Methodology.....	17
3.4 Referrals, skilled care and influence on district management systems .....	24
3.5 Changes in perceptions around pre and postnatal care.....	28
3.6 Enabling and hindering factors.....	33
4. Conclusions .....	36
5. Recommendations.....	37
5.1 Recommendations for the Comic Relief and Community Fund .....	37
5.2 Recommendations for funded partners.....	38
Bibliography .....	39
Annex 1 – Terms of Reference .....	41
Annex 2: Data Collection tools .....	45
A 2.1: Interview schedule for Key informants .....	45
A 2.2: Survey for frontline workers and beneficiaries .....	46
A 2.3: Survey for end-user beneficiaries (women and men).....	47
A 2.4: Focus Group Discussion.....	48
Annex 3 Outline of the PLA phases and meetings and the content covered.....	49
Annex 4: Uganda Healthcare System .....	51
Annex 5: Ethiopia Healthcare system .....	52
Annex 6: List of Respondents.....	53



Annex 7 – Evaluation matrix ..... 57  
 Annex 8: Data Tally Sheet ..... 58

**List of Tables**

Table 1: Selected indicators for programme target districts in Uganda and Ethiopia..... 3  
 Table 2: Selected MNCH indicators, Uganda and Ethiopia ..... 4  
 Table 3: Key informant Interviews with government and NGOs (district and Zonal level) ..... 7  
 Table 4: Beneficiary Interviews – community level ..... 7  
 Table 5: Participants in survey of frontline workers (subcounty/kebele level)..... 7  
 Table 6: Limitations and Solutions..... 8  
 Table 7: Satisfaction levels with quality of MNH services ..... 26  
 Table 8: Changes in perceptions around pre and postnatal care ..... 30

**List of Figures**

Figure 1: How well were the PLA sessions conducted? ..... 18  
 Figure 2: Effectiveness of the PLA methodology ..... 21

**List of Boxes**

Box 1: Project Objectives ..... 1  
 Box 2: Change Story 1: COMMONETH Project – The Game Changer ..... 12  
 Box 3: Change Story 2: Learnt strategies to take good care of my child and myself ..... 17  
 Box 4: Change Story 3: Effectiveness of PLA approach ..... 24  
 Box 5: Change Story 4: Improved staffing and service provision..... 28  
 Box 6: Change story 5: Improved health seeking behaviour ..... 32



## ACRONYMS

ANC	Antenatal Care
ARR	Annual Rate of Reduction
AWD	Acute Watery Diarrhoea
CAO	Chief Administrative Officer
CBOs	Community Based Organisations
CEmOC	Comprehensive Emergency Obstetric Care
CHF	Community Health Financing
CHWs	Community Health Workers
COMONETH	Community in which Mothers and New-borns Thrive
CSO	Civil Society Organisations
CUAMM	Doctors with Africa
EmOC	Emergency Obstetric Care
DHO	District Health Officer
DHS	Demographic and Health Survey
DHIS2	District Health Information Software 2
FGD	Focus Group Discussion
HC	Health Centre
HDA	Health Development Army
HEWs	Health Extension Workers
HIV	Human Immune Virus
HBB	Helping Babies Breathe
HSTP	Health Sector Transformation Plan
ICU	Intensive Care Unit
INGO	International Non-governmental Organisations
IRS	Indoor Residual Spraying
KII	Key Informant Interview
KMC	Kangaroo Mother Care
MakSPH	Makerere University School of Public Health
MCH	Maternal and Child Health
MMR	Maternal Mortality Rate
MSC	Most Significant Change
MoH	Ministry of Health
NMR	Neonatal mortality rate
NGO	Non-governmental Organisation
PNC	Postnatal Care
PLA	Participatory Learning and Action
PNMR	Perinatal Mortality Rate



PRI	Policy Research Institute
QA	Quality Assurance
RDC	Resident District Commissioner
RMNCAH	Reproductive Maternal Neonatal and Child and Adolescent Health
RMNCH	Reproductive Maternal Neonatal and Child Health
SMS	Short Messaging System
STI	Sexually Transmitted Infections
TBAs	Traditional Birth Attendants
UBOS	Uganda Bureau of Statistics
UFE	Utilization Focused Evaluation
UNFPA	United Nations
UNICEF	United Nations Children's Fund
VHT	Village Health Team
VSLA	Village Savings and Loans Associations
WDA	Women Development Army
WCF	Women and Children First



## DEFINITION OF KEY TERMS

**Maternal health (MH)** is defined as the health of the woman during pregnancy, childbirth, and postpartum period (usually 7 days after giving birth).<sup>1</sup> However, **maternal health** can also be considered as an umbrella term that covers

*“all the personal and physical factors, social and cultural issues, health conditions, policies, practices and collective circumstances in a woman’s life and body that enable her to emerge in a thriving state from pregnancy and childbirth. Maternal health starts during adolescence, well before motherhood, and lasts throughout a woman’s reproductive life and beyond menopause”.*<sup>2</sup>

**Perinatal health** is the health of the unborn baby and the new-born, from 22 weeks into the pregnancy and up to seven days after birth and includes stillbirth.

**Neonatal health** is the health of the baby for the first 28 days after birth.

**Maternal and child health (MCH)** refers to the health service provided to mothers (women of child-bearing age) and children. The targets for MCH are all women of reproductive age (15 - 49 years old), children, school-age population, and adolescents.

**Reproductive, Maternal, New-born, and Child Health (RMNCH)** covers the health concerns and interventions across the life course involving women before and during pregnancy; new-borns, the first 28 days of life; and children to their fifth birthday.<sup>3</sup>

**Participatory Learning and Action (PLA)** methodology supports communities in coming up with local answers to address problems faced by community members. It engages the latter in groups and guides them through monthly meetings in a four-phase action cycle to: a) identify problems; b) identify local solutions to these problems; c) plan and implement these solutions; and d) evaluate these solutions. Local facilitators use discussion prompts, picture cards and other tools to stimulate discussion.<sup>4</sup>

**Verbal Autopsy/Social Autopsy (VASA)** is a method used to ascertain the cause of death based on an interview with next of kin or other caregivers. This is done using a standardized questionnaire that elicits information on signs, symptoms, medical history, and circumstances preceding death. The cause of death, or the sequence of causes that led to death, is assigned based on the data collected by a questionnaire and any other available information.<sup>5</sup>

1 [https://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0006/354921/3.1-SDG-Fact-sheet-Maternal-Health.pdf](https://www.euro.who.int/__data/assets/pdf_file/0006/354921/3.1-SDG-Fact-sheet-Maternal-Health.pdf)

[https://www.who.int/health-topics/maternal-health#tab=tab\\_1](https://www.who.int/health-topics/maternal-health#tab=tab_1)

2 <https://blog.everymothercounts.org/what-is-maternal-health-125c26430c7e>

3 <https://www.ncbi.nlm.nih.gov/books/NBK361926/#:~:text=Volume%20Summary,children%20to%20their%20fifth%20birthday>

4

[https://static1.squarespace.com/static/5b2cea5e9f8770afe0868780/t/5b98469421c67c2e7962aefd/1536706198206/WCF\\_PLA\\_24072018.pdf](https://static1.squarespace.com/static/5b2cea5e9f8770afe0868780/t/5b98469421c67c2e7962aefd/1536706198206/WCF_PLA_24072018.pdf)

5 <https://www.jhsph.edu/research/centers-and-institutes/institute-for-international-programs/current-projects/verbal-autopsy-and-social-autopsy-studies-vasa/>



## ACKNOWLEDGEMENTS

The evaluation team would like to thank Comic Relief for entrusting us with this assignment and for the support provided throughout the evaluation process. The team is particularly grateful to Mr. Giancarlo Angelucci, and Poonam D'Cruze (Comic Relief), Joanna Drazdzewska (Women and Children First, UK), Eliana Valerio (Doctors with Africa CUAMM, Italy) and Dr. Peter Waiswa (Makerere University School of Public Health, Uganda) for coordinating the evaluation process.

Most of all, the team would like to emphasise their appreciation for all the individuals who agreed to share their experiences, insights, and perspectives during the data collection process in Goro Woreda (Ethiopia), Luuka and Oyam districts (Uganda).

We thank you all.

Kampala, May 20, 2021





## EXECUTIVE SUMMARY

### *Introduction and rationale of the programme*

The overarching dual aim of the Maternal and Child Health (MCH) programme was to support some of the most vulnerable and hard-to-reach women, their babies, and their families to access quality maternal and new-born care at the household and community level. It also aimed to strengthen their links with local primary healthcare providers and structures, while at the same time strengthening the health systems in the target communities more broadly. The programme was implemented in three locations. In Oyam district (Uganda) and Goro woreda (Ethiopia), the programme was through a collaboration between Doctors with Africa (CUAMM) and Women and Children First (WCF), while in Luuka district (Uganda) the programme was implemented by Makerere University School of Public Health. The programme was jointly funded by Comic Relief and National Lottery Community Fund.

In Oyam and Goro, the programme aimed to achieve 4 outcomes:

- ④ Improved Reproductive Maternal New-born Health (RMNH) home-care practices in the target communities.
- ④ Improved RMNH care-seeking practices.
- ④ Improved quality and accessibility of RMNH services.
- ④ Improved attitudes, cultural norms, and values in relation to RMNH.

In Luuka, the programme aimed to achieve the following 5 outcomes:

- ④ Increased maternal and new-born health service utilisation.
- ④ Improved screening for and management of mothers and new-borns exhibiting danger signs or classified as high risk.
- ④ Improved knowledge of new-born care among women.
- ④ Improved maternal and new-born birth outcome documentation at both community and health facilities.
- ④ Improved partnerships with community-based organizations for maternal and new-born health.

### *Objectives of the evaluation*

The overarching goal of this final evaluation is **learning**. The evaluation was expected to contribute to understanding what **impact** the programme had on pre and postpartum care (both at home and in health facilities), what lessons can be learned from the implementing agencies' participatory approaches, and whether these can be replicated in similar contexts.

This evaluation provides evidence on: 'What works', 'for whom' and 'how it works', specifically what conditions and factors must be secured to foster effective community engagement in improving the health of mothers and babies, and influence health management at district level.

### *Methodology*

The evaluation team chose to anchor the evaluation on the **Utilization Focused Evaluation (UFE)**<sup>6</sup> and the **Realist Evaluation (RE)** approach. The **UFE** approach enabled the evaluation team to ensure that key stakeholders were effectively engaged throughout the process and that the resulting products are useful and provide for effective and rapid integration into the learning processes. The **RE** approach guided the analysis to focus on what worked, when, how and for whom.

The evaluation team employed various qualitative data collection methods to obtain needed evidence to effectively answer the 6 evaluation questions. These included document reviews, case-stories, in-depth interviews with key stakeholders at district/woreda level, zonal levels and the implementing

<sup>6</sup> [https://www.betterevaluation.org/en/plan/approach/utilization\\_focused\\_evaluation](https://www.betterevaluation.org/en/plan/approach/utilization_focused_evaluation)



partners, interviews with frontline workers mainly operating at subcounty/kebele levels and community level, as well as community level beneficiaries including women and men. Save for the interviews with beneficiaries in Goro, all interviews were done remotely by phone, Zoom or Skype, and via a survey mounted on an online platform (Google forms).

### **Sampling**

The evaluation participants were selected from lists of stakeholders provided by implementing partner organisations, and mainly those that could be reached by phone or other on-line communication platforms.

Since the evaluation was designed to be remote, only participants that could not be accessed at least via a phone were excluded.

### **Limitations**

The main challenge for this assessment was the COVID-19 pandemic-imposed lockdown, which limited choices in terms of data collection methods.

The team relied on use of digital communication platforms such as telephone, Zoom and WhatsApp, thus some potential participants might have been excluded. Some community level participants do not own phones, and some were out of range of connectivity, and, of course, there were the high chances of non-response to self-administered questionnaires. To overcome these challenges, the team opted to use different tools to obtain data from varied sources that could be triangulated. The team also allowed more time for field data collection, using all possible means to reach the selected participants.

### **Key Findings**

#### **MCH program impact on infant mortality and stillbirths**

Anecdotal evidence has shown that across the three programme locations (Goro, Ethiopia; and Oyam and Luuka districts, Uganda) there is significant reduction in infant mortality and stillbirths in the target communities. The programme has also contributed to the strengthening of health systems in the districts and communities, through the equipping and supplying of necessary medicines to the health centres to enable them to provide quality Maternal New-born Child Health (MNCH) services to women and children. The health staff have also received training under the programme. And because of the increased referrals for skilled birth care at the target health centres, more staff (midwives, clinical officers, and nurses) have been recruited and posted to these health centres across the three programme locations.

The assessment also revealed that awareness-raising activities across the three programme locations have contributed to changes in attitudes, behaviour and practices of women and men regarding MNCH. There is an improvement in health-seeking practices, as evidenced by the increased uptake of Antenatal Care (ANC), Postnatal Care (PNC) and Skilled Birth Attendance (SBA). Lastly, the assessment has revealed that there is a reduction in the number of neonatal and maternal deaths and stillbirths in the target communities.

#### **The most successful strategies in implementation of pre and postnatal care practices**

The evaluation has shown that beneficiary communities have knowledge of and have adopted several strategies to implement the WHO recommended pre and postnatal care practices. The most successful strategies adopted include: disease control (e.g prevention of malaria, vaccination/immunisation, maintenance of hygiene through improved water and sanitation practices, body hygiene), attendance of ANC, seeking deliveries at health centres under SBA, breastfeeding, skin-to-skin methods to help babies bond with their mothers and also to receive the necessary body warmth, helping babies to breathe (HBB), mama delivery kits, following recommended nutritional practices, and preparing for deliveries by commencing saving early enough.

Most of the Participatory Learning Action (PLA) participants in Goro and Oyam and the mothers that participated in the community sessions in Luuka reported they were practicing most of the recommended prenatal, birth and postnatal care practices. However, this is not the case with the



non-participating women in the community in the three programme locations. Therefore, there is need for more time in order to reach out to more members of the communities in the three programme locations that have not yet adopted the recommended MNCH practices and to increase their awareness and foster positive behavioural change.

The major challenge is that prenatal, birth and postnatal practices are entrenched in societal norms and traditional practices of the target communities in the two countries. In addition, a number of unsafe customary practices are part of traditional rites of passage. More time is also needed to increase participation amongst men, older women and youth of reproductive age, as well as religious leaders who were missed during this phase of the programme.

### **Effectiveness of the PLA methodology in mobilising communities to participate in the programme, learn, and stimulate action on RMNCAH**

The PLA methodology was found to have effectively mobilised the Oyam (Uganda) and Goro (Ethiopia) communities to participate in the programme. Two hundred and ten PLA groups (100 in Goro and 110 in Oyam) were formed. PLA sessions enabled participants – mainly women in both countries – to learn about and understand Reproductive, Maternal, New-born and Child Health (RMNCH) at individual and community level, to identify priorities, and to decide what actions to take to mitigate the prioritised problems.

While facilitation of the PLA groups was effective in the two countries, the evaluators' assessment is that, in terms of the depth of participants' understanding of the processes and their application of the knowledge, results were more observable in Goro, Ethiopia, than in Oyam, Uganda. The main challenges for PLA in the two programme locations were participant absenteeism and tardiness due to other commitments of the target participants, such as farming, heavy rains that caused occasional flooding making access to meeting venues difficult. Another challenge were the social norms that limit women's and young people's participation. In addition, in Oyam, as opposed to Goro, each facilitator worked with two PLA groups, which is a time-demanding and tedious exercise.

The PLA was structured in a four-phase action cycle, that includes: problem identification; identification of local solutions to these problems; planning and implementation of these solutions; and evaluation of these solutions. These phases were covered in 14 sessions – one or two session(s) per month. (See Annex 3 for a description of each of the 14 sessions).

Data from Goro and Oyam suggests that the most difficult stages to implement were mainly the mobilization stage (for both Oyam and Goro) and stages that required community contribution. In Goro, Ethiopia, the COVID-19 lockdown prevented six groups from completing all the 14 stages, because of the delays in the initial mobilisation stages and the slow pace in completion of sessions. The most affected groups were those meeting once a month as opposed to those meeting twice a month. Data also suggests that in Goro (as opposed to Oyam) the sessions were more thoroughly aimed at ensuring that participants understood the content before moving on to the next session. In Oyam, most of the PLA groups added other activities to the PLA agenda, including savings and loans schemes and community health financing schemes. This combining of PLA activities with other activities increases community solidarity while also solving some of the very challenges that are drivers of poor maternal and child health.

### **Increase in referrals, improvement in skilled care and effect on district management systems**

The analysis has shown that there is an increase in referrals across the three programme locations. This can be attributed to demand for services due to the increased awareness of the need for MNCH. On the one hand, the assessment has revealed that most of the women in the target communities are now seeking and delivering at health centres. The Village Health Team and Community Health workers in the two countries indicated that they were referring more expectant mothers to health facilities.

Additionally, there was evidence that services at the target health centres had improved, making them more hospitable to expectant mothers. Health personnel were retrained and are more motivated, caring and receptive to mothers. For example, in Luuka district in Uganda, Emergency



Obstetric Care services are now accessible to mothers, thanks to the programme. Health centres were equipped and received medical and other supplies. This has culminated in increased service uptake. However, some challenges exist -- for example, a few health centres in Goro lacked quality service. CUAMM should investigate this challenge.

### **Changes in perceptions around pre and postnatal care**

Perceptions of the majority of the mothers in the target communities of pre and postnatal care significantly changed, as evidenced by the increased uptake of pre and postnatal services and of RMNCH services in general. More members of the community have knowledge of the risks of not adhering to pre and postnatal care practices. They can recognise early danger signs in a new-born, or during pregnancy, etc.

There is also an increase in participation of men in pre and postnatal care activities across all three programme locations, although in varying proportions and intensity. This male engagement needs to be appreciated and recognised. For instance, even if they do not accompany their spouses for antenatal care (ANC) and postnatal care (PNC) visits, more men are supportive of their spouses' needs regarding pre and postnatal care and skilled birth attendance for a safe delivery, and are providing for things such as proper feeding, clothing, transport, and taking on additional homecare responsibilities.

However, there were no interventions targeting older women's engagement. Nonetheless, older or senior women are involved in the Village Health Team's (VHTs) work in Uganda or are part of the Women Development Army (WDA) in Ethiopia or are former Traditional Birth Attendants (TBAs) and are supporting referrals, RMNH care and counselling. In Oyam and Goro, the older and senior women also participated in PLA activities, along with other community members.

### **Factors that enabled or hindered the implementation of national maternal and new-born health strategies**

Several factors have facilitated the successful implementation of the national maternal and new-born health strategies in partnership with national governments, local health authorities and frontline health providers. The programme has benefited from the local implementing partners' knowledge of the context, particularly CUAMM and MakSPH, which have operated for a long time in Oyam and Goro, and MakSPH in Luuka, respectively. Both countries also have well-structured health delivery systems that can support effective delivery of reproductive, maternal, new-born, child and adolescent health (RMNCAH) services if supported. Other facilitative factors include the changed attitudes and motivation of health workers, responsiveness of local health authorities, and community ownership of the programme.

The factors that have hindered the programme include household poverty, which limits capabilities of many households to seek and access RMNCAH services, and negative social norms and religious beliefs. Gender inequality has also been a hindrance, as it limits women's participation in decision-making even on issues that affect their lives (such as whether to attend ANC or not), as well as their ownership and control over resources. The economic status of the targeted women beneficiaries was a determinant in the uptake of some maternal and new-born strategies. Other limiting factors include limited government funding for the health sector; poor remuneration and motivation of health workers; population pressure on the existing service capacity and the challenges arising from the COVID-19 pandemic.

### **Conclusions**

- ② The evaluation has shown that the MCH programme funded by Comic Relief and the National Lottery Community Fund had a positive impact on infant mortality and stillbirth across the three programme sites. There was anecdotal evidence of a reduction in infant mortality. Participants in the interviews from communities and health workers suggested that there were fewer deaths of new-borns and infants in their communities during the intervention period compared with the period before. They also indicated that there were fewer stillbirths in the targeted communities, which is attributed to changes in the health seeking behaviour of expectant mothers. However, the challenge is the ability of the health centres to sustain



the MNCH services at the same level beyond the programme period, given the limited government funding to the health sector.

- ② The **strategies employed in pre and postnatal care**, as adopted by mothers, were found to be successful. However, there is a gap in knowledge among community members that did not participate in the programme's community sensitisation activities, especially men and young people (girls and boys) and older women. Hence, there is a need to invest in more programme time to further train and sensitise communities for effective application of those strategies. There is still need for community awareness and for ensuring that all mothers deliver in health centres under the care of a skilled birth attendant.
- ② The **PLA methodology** has proven to be effective in mobilising communities to participate in the programme in Oyam and Goro. It has also been an important platform for facilitating learning, prioritising community issues and inspiring action using local resources. However, the PLA sessions in Goro were interrupted by the COVID-19 lockdown. Compared with Goro, where each facilitator was responsible for one PLA group, in Oyam the facilitators' workload was higher, as each facilitator was responsible for two PLA groups. The district/woreda and subcounty Community Development Officers' participation was also not consistent, and the community action plans were not linked to the subcounty/kebele plans.
- ② There has been an increase in **referrals** for each of the three projects. Increased referrals were enabled by: motivating VHTs to identify, refer and follow-up expectant mothers, funding the ambulance system, equipping health centres with medical supplies, and training health workers. The challenge is whether the targeted health centres will be able to sustain the increased demand for services by the communities, given the frequent stock-outs of medicines and other medical supplies in government health facilities. In addition, the referral system may not remain functioning at the same level that was maintained during the programme time, as the government may not maintain the ambulances and the constant supply of adequate medical commodities that are essential for effective MNH services at the health centres. More resources should be allocated in order to maintain ambulance services and to cover the purchase of drugs and the payment of allowances to district level staff to provide regular support supervision.
- ② **Perceptions around pre and postnatal care** have significantly changed in the target communities throughout the target programme location, although in varying proportions. The change in perceptions is, however, constrained by various factors, such as household poverty and social norms that remain dominant in these areas, where RMNCH issues are generally perceived as women's issues. The assessment did not find deliberate efforts to engage older women and girls, as well as young men, in the programme interventions.
- ② The assessment identified several **factors that facilitated** the success of the programme. They include: the local implementing partners' knowledge of the context; availability of a well-structured health delivery system; the choice to work with public health centres that offer free reproductive, maternal, new-born, child and adolescent health (RMNCAH) services. Others include responsiveness of local health authorities and community ownership of the programme. Conversely, there were also several **limiting factors**, which need to be addressed in future interventions. These include household poverty, social norms and religious beliefs, gender inequality, and the occupation of the targeted women beneficiaries. Other factors include limited government funding to the health sector; poor remuneration and motivation of health workers; population pressure and the COVID-19 pandemic related challenges.

### **Recommendations**

1. There is need for district health departments and planning departments to track maternal and neonatal and infant mortality rates to inform planning for an effective MNCH response. Future phases of the programme should support the development of such a tracking system.



Said support should start from the current target districts and eventually be rolled out to other districts and/or be integrated into the DHIS 2.

2. Given that the intervention aimed to influence behavioural change and practices, which require a lot of time to change, and given the interruptions in the programme flow towards the end due to the COVID-19 pandemic, there is need for continued funding for the interventions in the target districts in order to sustain the community sensitisation and to effectively foster positive change in practices. In addition, the scope should be widened to address all the elements of RMNCAH.
3. PLA facilitation handbooks should be revised to accommodate issues like saving and credit to improve household livelihoods, and community health financing, since these complement each other in ensuring sustainable health outcomes.
4. Future programs should include lobbying and advocacy for increased government funding to improve MNCH service delivery.
5. The evaluation shows positive changes in perceptions around pre and postnatal care service uptake. However, uptake of FP services and male engagement remain low. Greater and more sustained investment in awareness-raising and sensitisation of communities is needed to change sociocultural norms.
6. Future programmes should include gender and age considerations, including engagement of different population groups, such as men, older women and youth.



## 1. INTRODUCTION AND BACKGROUND

### 1.1 Introduction

This is a final evaluation of the Maternal and Child Health programme implemented in Ethiopia's Goro Woreda/District, and in Oyam District and Luuka District in Uganda. These interventions in the three locations are part of the Comic Relief initiative whose aim is to support some of the most vulnerable women, their babies and their families, that live in hard-to-reach areas, to access quality maternal and new-born care at the household and community level. The programme is implemented by Makerere University School of Public Health (MakSPH) in Luuka District, Uganda; Women and Children First (WCF) UK in Oyam District, Uganda; and Doctors with Africa (CUAMM) in Goro Woreda, Ethiopia. CUAMM and WCF are collaborating in the implementation of the programme in Oyam District in Uganda and in Goro Woreda in Ethiopia.

### 1.2 Programme Description

The programme under review is funded by the Comic Relief and the National Lottery Community Fund initiative, a partnership with a worth of £5.5m, announced in 2015. The rationale for the programme was the recognition of the fact that, although the number of deaths of children under five years of age had halved since 1990, mortality rates amongst new-borns had remained consistently high.

This programme aimed to contribute to the global agreement on a shared sustainable development agenda 2030, and more specifically SDG 3 - Good health and wellbeing.<sup>7</sup>

The initiative focused on the delivery of people-centred, primarily community-based, maternal, perinatal and neonatal health packages. Its chief aim was to support extremely vulnerable and hard-to-reach women, their babies and their families in accessing quality maternal and new-born care at the household and community level, while strengthening their links with local primary health care

#### Box 1: Project Objectives

**Community in which Mothers and New-borns Thrive', Luuka District, Uganda**, implemented by Makerere University School of Public Health (MakSPH) had a target of reaching 29,072 direct beneficiaries. It was funded at £504,999 and aimed to achieve the following outcomes:

- ② Increased maternal and new-born health service utilisation;
- ② Improved screening for and management of danger signs in mothers and new-borns or amongst those classified as high risk;
- ② Improved knowledge of new-born care among women;
- ② Improved maternal and new-born birth outcome documentation at both community and health facilities;
- ② Improved partnerships with community-based organisations for maternal and new-born health.

**Improving Maternal, Perinatal and New-born Health and Reducing Mortality in Oyam District, Uganda**, implemented by Women and Children First, UK in partnership with CUAMM targeted to reach 108,317 in Oyam District, Northern Uganda. The project was implemented in the Myene and Ngai sub-counties. The project was funded at £792,823 and intended to achieve the following outcomes:

- ② Improved RMNH home-care practices in Myene and Ngai sub-counties of Oyam District;
- ② Improved RMNH care-seeking practices in Myene and Ngai sub-counties of Oyam District;
- ② To improve quality and accessibility of RMNH services in Myene and Ngai sub-counties of Oyam District
- ② Improved attitudes, cultural norms and values in relation to RMNH in Myene and Ngai sub-counties of Oyam District.

**Improving Maternal, Perinatal and New-born Health and Reducing Mortality in Goro Woreda, Ethiopia** implemented by CUAMM in partnership with WCF, UK had a target of reaching 39,893 beneficiaries. It was funded at £714,999 and aimed to achieve the following outcomes:

- ② Improved Reproductive, Maternal and New-born Health (RMNH) home-care practices in Goro Woreda;
- ② Improved RMNH care-seeking practices in Goro Woreda;
- ② To improve quality and accessibility of RMNH services in Goro Woreda;
- ② Improved attitudes, cultural norms and values in relation to RMNH in Goro Woreda.

<sup>7</sup> <https://sdgs.un.org/2030agenda>



providers and structures. In the long-term, the ambition was to complement national health programmes, while strengthening health systems more broadly. The programme was implemented in three locations, Luuka and Oyam districts in Uganda; and Goro Woreda in Ethiopia.

The following activities were conducted across the three programme locations in pursuit of these impacts:<sup>8</sup>

- ② Community sensitisation – through Participatory Learning Action (PLA) Group activities in Goro and Oyam (see Annex 3), and through video halls in Luuka;
  - ② Training of CHWs (Luuka), VHTs (Oyam) and HDAs and HWEs (Goro) to enable them to undertake active surveillance and provide community-based maternal and new-born health in their respective communities;
  - ② Health systems' strengthening, which included identifying and building capacity of health posts, health centres and targeted hospitals in Oyam and Goro; providing need-based packages of essential equipment, drugs and supplies to guarantee provision of basic services; training of midwives on quality antenatal care and neonatal care and collection of reliable data; providing regular supportive supervision of health workers; and provision of free ambulance services;
- Advocacy/evidence for decision-making.

All three districts can be characterised as remote and rural with low socio-economic and health indicators. The programme targeted a population of 260,000 in Luuka, 366,000 in Oyam and 58,301 in Goro. The population in these districts have to travel long distances (more than 15 kms) to reach the nearest health facility that can offer Comprehensive Emergency Obstetric care. Luuka district, compared with Oyam and Goro, does not have a district level hospital. The three districts also had a weak referral system, a lack of key equipment, supplies and drugs, and knowledge gaps amongst personnel.<sup>9</sup>

It is against this backdrop that the programme elected to take a health-systems strengthening approach by supporting all the public health facilities in the target districts. Altogether, the programme supported strengthening of 79 health facilities (29 in Luuka, 24 in Oyam and 26 in Goro), ranging from health posts to hospitals, to enable them to provide effective pre and post-natal care and family planning services in the three locations. In Oyam and Goro, these were linked to the CUAMM supported Hospitals, while in Luuka, they were linked to Kiyunga HC IV.

Needs assessment studies conducted by the funded partners to inform the design of the programme interventions in the three locations showed a number of drivers of the maternal mortality rate (MMR), perinatal mortality rate (PNMR) and neonatal mortality rate (NMR). These include:

- ② Inadequate knowledge of how to prevent or recognise new-born illness
- ② Low knowledge of pre- and post-natal care practices, and home-care practices
- ② Dangerous practices in the care of pre-terms and sick new-borns
- ② Lack of referral services
- ② Lack of integration of services along the continuum of care<sup>10</sup> (such as prevention of malaria in pregnancy, prevention of mother to child transmission, and family planning services)
- ② Social norms and values that contradict safe pre- and post-natal care practices, as well as discriminate against women
- ② Economic factors
- ② Lack of partner support
- ② Poor quality and accessibility of RMNH services
- ② Inadequate RMNH care-seeking practices
- ② Weak RMNH policy implementation and resource allocation – challenges include poor governance, management, financial and resource inputs.

<sup>8</sup> CUAMM Project document, WCF Project document, and MakSPH project document

<sup>9</sup> CUAMM. 2017. Project proposal document

<sup>10</sup> The "Continuum of Care" for maternal, new-born and child health (MNCH) include integrated service delivery for mothers and children from pre-pregnancy to delivery, the immediate postnatal period, and childhood





Table 1: Selected indicators for programme target districts in Uganda and Ethiopia

Indicator	Luuka District	Oyam District	Goro Woreda
Population	260,000	366,200	58,301
Total number of health facilities	29	24	26
Hospitals	0	1	1
Health centre IV	1	1	4
Health Centre III	8	5	
Health Centre II/health post	20	17	21
Population living within 5 kms of a health facility	49%	32%	Not available
Proportion of women attending the recommended ANC fourth visit	30%	48%	47%
Percentage of women that receive PNC within two days of delivery	46%	37%	40%
Percentage of health facility deliveries	73%	42%	50%

The three districts had very poor MNH indicators. For example, 49% of the population in Luuka live within 5 kms of the nearest health facility compared with 32% in Oyam and in Goro Woreda, the average distance to the nearest health facility is 10 kms.<sup>11</sup> The three districts were selected because they also had a poor record of access to antenatal and post-natal care, and of health facility deliveries (Oyam and Goro). Luuka district, with a higher percentage of the population within 5 kms of the health facility and a higher number of Health Centre IIIs -- which is a level that offers Basic Emergency Obstetric Care (BeMOC) services had a higher percentage of health facility deliveries, compared with Oyam and Goro. (See Table 1 above for selected indicators for programme target districts in Uganda and Ethiopia).

In Luuka District, Uganda, the programme implemented by MakSPH aimed to design and implement a community-owned but facility-linked district-wide intervention promoting high coverage with preventive care while improving quality of clinical care equitably, leading to reduction of maternal, perinatal and neonatal mortality in rural Uganda. The intervention also aimed to empower communities and strengthen health facilities and enable them to become more responsive towards outcomes for mothers and new-borns.

The programme in Goro Woreda, Ethiopia and Oyam District, Uganda shared the same objectives and strategies and were implemented by the partners, Women and Children First, and CUAMM. In both cases, WCF, UK provided technical expertise in community mobilisation and empowerment, using Participatory Learning and Action (PLA), while their counterpart, CUAMM, was responsible for the health-related technical inputs of the programme. They only interchanged the grant management roles. In Ethiopia, CUAMM was the grantee, while in Uganda, WCF, UK was the grantee.

### 1.3 The context

#### **The situation of maternal and child health in Uganda and Ethiopia**

Table 2 below provides snap shots of the situation of maternal, new-born and child health in Uganda and Ethiopia and the three target districts of the programme. Annexes 4 and 5 also provide briefs of the healthcare system for Uganda and Ethiopia, respectively, in which the funded programme interventions operated. In Uganda, the health care system starts with the Village Health Team (VHT), through to Health Centres II, III, and to the national referral hospital. In Ethiopia, the health service delivery system is organised in three levels (Primary, Secondary and Tertiary levels) with a shared responsibility between state and federal governments. The health care system is also leveraged by a Health Extension Programme (HEP) at the community level driven by a health development army.

<sup>11</sup> Doctors with Africa CUAMM. 2015. Comprehensive Baseline Need Assessment on Maternal, Neonatal and Child Health Services Implantation in 12 Selected Health Centers



Table 2: Selected MNCH indicators, Uganda and Ethiopia

Selected maternal, neonatal and child health indicators	Uganda	Ethiopia
Maternal mortality ratio for women aged 15-49	336 deaths per 100,000 live births (WHO; 2018)	420 per 100,000 live births <sup>12, 13</sup>
Stillbirth rate	17.8 per 1000 total births	24.6 per 1000 total births <sup>14</sup>
Infant mortality rate	43 deaths per 1,000 live births (UBOS, UDHS 2016)	43 deaths per 1,000 live births (EMDHS, 2019)
Under-five mortality rate	64 deaths per 1,000 live births (UBOS, UDHS 2016)	55 deaths per 1000 live births (EMDHS, 2019)
Neonatal mortality rate	42 deaths per 1,000 live births (UBOS, UDHS 2016)	30 per 1000 live births (EMDHS, 2019)
Percentage of deliveries under Skilled Birth Attendant	74% (UBOS, UDHS 2016)	61% (EDHS, 2016)
Percentage of pregnant women that attend at least 4 ANC visits	60% (UBOS, UDHS 2016)	43% (EMDHS, 2016)
Percentage of women that receive PNC	56% (UBOS, UDHS 2016)	34% (EMDHS, 2019)
Adolescent birth rate in the age category 15-19 years	135 per 1000 live births (UBOS 2016)	79 births per 1000 (EDHS, 2016)

In Uganda<sup>15</sup> and Ethiopia<sup>16</sup> the leading causes of maternal deaths include haemorrhage, eclampsia (high blood pressure), and infection. In Uganda, almost 28% of maternal deaths occur in young women aged 15 – 24 years. The majority of these maternal deaths are preventable.

The leading causes of stillbirths and neonatal deaths in Uganda<sup>17</sup> and Ethiopia<sup>18</sup> as in many developing countries, are linked to maternal factors including hypertension, diabetes, maternal infection (e.g. syphilis, malaria, HIV), pre-term births, birth asphyxia, maternal undernutrition, obesity, prolonged labour, and accidents. In Uganda, an estimated 40,000 stillbirths occur each year, making it the country with the 10th highest number of stillbirths in the world. However, most stillbirths in both countries are often unreported in official statistics and are invisible to health policy makers.<sup>19</sup> Likewise, the under-five mortality rates in both countries are mostly attributable to neonatal conditions, as well as three common childhood illnesses, mainly malaria, pneumonia, and diarrhoea.<sup>20, 21</sup>

A review of literature has revealed that in recent decades Ethiopia, has made good progress in reducing maternal deaths (average annual rate of reduction 2000-2015 (ARR) of 6.0% versus the worldwide rate of 3.0%, but has seen slower progress in reducing neonatal deaths (ARR of 3.7% versus 3.1% globally) and stillbirths (ARR of 1.8% versus a global 2.0% rate).<sup>22</sup> However, the

12 [http://www.countdown2015mnch.org/documents/2014Report/Ethiopia\\_Country\\_Profile\\_2014.pdf](http://www.countdown2015mnch.org/documents/2014Report/Ethiopia_Country_Profile_2014.pdf)

13 Lawn et al. 2016 Stillbirths: rates, risk factors and acceleration towards 2030. Lancet

14 Ibid

15

<https://www.souluganda.org/maternalhealth#:~:text=In%20Uganda%2C%20the%20leading%20causes,of%20death%20are%20largely%20preventable.>

16

<https://pubmed.ncbi.nlm.nih.gov/25489180/#:~:text=In%20the%20last%20decade%2C%20however,significantly%20in%20the%20last%20decade.>

17 <https://www.tandfonline.com/doi/full/10.3402/gha.v8.24011>

18

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6486678/#:~:text=The%20leading%20causes%20for%20neonatal,country%20%5B16%2C%2017%5D.>

19 Ibid

20 [https://www.unicef.org/uganda/what-we-do/child-survival-development#:~:text=Uganda%20has%20over%20the%20years,AIDs%20\(7%20p](https://www.unicef.org/uganda/what-we-do/child-survival-development#:~:text=Uganda%20has%20over%20the%20years,AIDs%20(7%20p)

21 <https://bmcpubhealth.biomedcentral.com/articles/10.1186/s12889-019-7273-4>

22 Lawn et al. 2016 Stillbirths: rates, risk factors and acceleration towards 2030. Lancet



progress in Uganda has been slight.<sup>23</sup> Both countries still rank among the top 40 countries in the world with high maternal, new-born and child mortality rates.<sup>24</sup>

See Table 1 above for additional relevant information on target districts in Uganda and Ethiopia.

### 1.4 Evaluation purpose and objectives

The overarching goal of this final evaluation is **learning**. The aim was to contribute to understanding the programme's **impact** on pre and postpartum care practices (both at home and in health facilities); what lessons the stakeholders can learn from the approaches employed in the implementation of the programme; and whether these can be replicated in similar contexts. It also served as the final evaluation for programme interventions in Oyam and Goro implemented by CUAMM and Women and Children First, UK, respectively. The evaluation provides evidence regarding: 'What works', 'for whom', when, and 'how it works', specifically, what conditions and factors must be secured to foster effective engagement of communities in improving the health of mothers and babies, and to influence health management at district level.

### 1.5 Evaluation questions

The following six specific questions guided this evaluation.

1. What impact did the programme have on infant mortality and stillbirths, and what facilitated or hindered its implementation (e.g., change in attitudes, overcoming tangible barriers, self-efficacy of women, working closely with health workers, etc.)?
2. Which strategies were the most successful in the implementation of pre and postnatal care practices and skilled delivery (including home care practices, such as exclusive breastfeeding, skin-to-skin contact from birth, early onset of breastfeeding, ensuring babies are kept warm and ensuring basic prevention of infections), and why?
3. How effective was the PLA methodology in mobilising communities to participate in the programme, learn, and stimulate action on RMNHC issues in their communities? How well were the PLA meetings conducted? What were the challenges in conducting/participating in the meetings? Which stages of the PLA meetings were difficult to implement?<sup>25</sup>
4. Was there an increase in referrals to health facilities and improvement in skilled care during labour and birth, and how have these changes informed the district management systems?
5. To what extent have perceptions around pre and postnatal care changed in the target communities, and how successful were implemented strategies (which included engaging men and older women)?
6. What hindered or facilitated the implementation of national maternal and new-born health strategies in partnership with national governments, local health authorities and frontline health providers?

All the funded partners have contributed to the development of the questions that guided this learning evaluation.

<sup>23</sup> UBOS. 2017. Uganda Demographic and Health Survey (UDHS) 2016

<sup>24</sup> [https://www.unicef.org/uganda/press-releases/more-women-and-children-survive-today-ever-un-report#:~:text=Like%20many%20countries%20around%20the,Health%20Survey%20\(UDHS\)%202016.&text=Infant%20deaths%20als%20reduced%20from,1%20C000%20live%20births%20in%202016.](https://www.unicef.org/uganda/press-releases/more-women-and-children-survive-today-ever-un-report#:~:text=Like%20many%20countries%20around%20the,Health%20Survey%20(UDHS)%202016.&text=Infant%20deaths%20als%20reduced%20from,1%20C000%20live%20births%20in%202016.)

<sup>25</sup> This is an additional learning question based on the suggestions from WCF and CUAMM



## 2. METHODOLOGY

### 2.1 Overall approach

The evaluation was qualitative, anchored on the **Utilization Focused Evaluation (UFE)**<sup>26</sup> and the **Realist Evaluation** approaches. The **UFE** approach enabled the evaluation team to ensure that key stakeholders were effectively engaged throughout the process and that the resulting products are useful and provide for effective and rapid integration into the learning processes.

The UFE was implemented through the following steps:

- a) Identification and defining of primary intended users and other stakeholders that could contribute to the evaluation, through review of the documentation that mapped the following:
  - ② Donors: Comic Relief, and National Lottery Community Fund
  - ② Funded partners: MakSPH, CUAMM and Women and Children First, UK
  - ② Frontline workers: Community workers (District Health Officers (DHOs), Doctors/Clinical Officers, midwives, nurses, health educators, Village Health Teams, Community Health Workers (CHWs), etc.
  - ② Others: Local Governments, NGOs operating in the intervention locations, etc.
- b) Gaining commitment of the Client's representatives and the funded partners as end users. This was achieved through engaging and sharing with them the Inception Note and receiving their comments from Comic Relief, CUAMM and WCF. This enabled the team to explain the approach and tools that the team would use and why they were chosen.
- c) The process of the Inception Note preparation and ensuing discussion led to a revised inception note that was shared with the funded partners, setting the stage for the conduct of the assignment.
- d) Analysis and interpretation of findings and reaching conclusions. The evaluation team has analysed data and interpreted findings and again engaged with Comic Relief and the funded partners as intended users through sharing of draft reports in order to agree on the general structure of the report before producing the final draft report.
- e) The final report will be presented at a date yet to be determined by the client, to enable the sharing of the findings as part of the learning process.

The **Realist Evaluation (RE)** served as guide in the analysis through comparison and contrasting of data from the three programme locations over the programme time span, what MNH interventions, strategies and practices were more impactful, how the interventions benefited each target beneficiary groups, and why.

### 2.2 Data collection instruments

Aside from face-to-face in-depth interviews conducted with programme beneficiaries in Goro, Ethiopia, all data collection was remote due to the threat posed by COVID-19.

The following data collection tools were used:

**Document review:** the evaluation team did an in-depth review of available documentation and literature relevant to the programme under review. All documents reviewed are included in the Bibliography at the end of this report.

**In-depth interviews:** the evaluation team conducted interviews with three categories of stakeholders: officials working with government and non-governmental agencies working at the district level and zonal levels; the funded partners; and beneficiaries. Interviews were conducted

<sup>26</sup> [https://www.betterevaluation.org/en/plan/approach/utilization\\_focused\\_evaluation](https://www.betterevaluation.org/en/plan/approach/utilization_focused_evaluation)



through phone calls, WhatsApp and Zoom calls. See Tables 3 and 4 below for a breakdown of each of the participant groups.

Table 3: Key informant Interviews with government and NGOs (district and Zonal level)

Key informant Interviews	Males	Females	Total
Luuka District, Uganda	4	1	5
Oyam District, Uganda	5	0	5
Goro Woreda, Ethiopia	4	3	7
<b>Total</b>	<b>13</b>	<b>4</b>	<b>17</b>

Table 4: Beneficiary Interviews – community level

Interviews with community participants	Males	Females	Total
Luuka District, Uganda	03	08	11
Oyam District, Uganda	08	32	40
Goro Woreda, Ethiopia	03	24	27
<b>Total</b>	<b>14</b>	<b>64</b>	<b>78</b>

**Survey of frontline workers via Google Forms:** the evaluation team sent out a survey questionnaire via Google Forms platform to frontline workers including health workers, community development workers, Health Extension Workers and NGO workers operating at sub county /kebele level. Those that could not manage to complete the survey for example because of lack internet access completed and sent the paper copy and their responses were transcribed and uploaded on the survey platform. See Table 5 below for a breakdown of the participants by programme location.

Table 5: Participants in survey of frontline workers (subcounty/kebele level)

Frontline workers	Males	Females	Total
Luuka District, Uganda	06	10	16
Oyam District, Uganda	16	15	31
Goro Woreda, Ethiopia	08	10	18
<b>Total</b>	<b>30</b>	<b>35</b>	<b>65</b>

**Case studies/ Stories of change:** although the evaluation had initially proposed to do full scale Most Significant Change (MSC) workshops, the team later found it not tenable. The strategy was therefore modified to collect most of the stories of change during interviews. A total of 5 change stories were compiled from interviews with key informants, frontline workers and beneficiaries and have been used in the report.

## 2.4 Approach to data analysis

The data collected through document reviews, surveys, KIIs interviews, and change stories/case studies were tallied using an excel sheet that brought together all information corresponding to any one question, as detailed in the evaluation matrix. The use of this tool ensured that all data responding to each question was appropriately collated, and facilitated the triangulation of data from different sources.

## 2.5 Ethics and participation

The evaluation team ensured that it adhered to the Comic Relief’s Safeguarding Code of Conduct and key safeguarding processes for all the delivery partners involved in this programme, as clearly set forth in the contract. Where face-to-face data collection was done, the team adhered to CUAMM’s



Travel Safety Guidelines, PRI and the Ethiopia National Standing Operating Procedures and WHO COVID-19 safeguarding guidelines.

## 2.6 Limitations and challenges

Aside from the COVID-19 pandemic, which limited travel and imposed restrictions on in-person interactions, which were addressed, through a methodological modification.

Table 6: Limitations and Solutions

Limitation	Solution
This was a remote-based evaluation, which depended on use of digital communication platforms, such as telephone, Zoom and WhatsApp. This means that there is a strong likelihood that some potential participants could have been excluded, creating a risk for bias.	The team ensured that many stakeholder groups were reached to ensure that the data collected is representative of the views of as many members of the target communities as possible.
Data collection from community beneficiaries (participants in the project) in Goro was hindered as participants could not be accessed and interviewed remotely. This delayed the assignment by over two months.	Face-to-face field data collection option was organised after approval by the client. However, a reduced but representative number of communities were visited in the limited time available to undertake and complete the interviews.
It was difficult to conduct Focus Group Discussions mainly because of poor internet connectivity and difficulty in agreeing on time for interviews.	The would-be participants for FGDs were therefore interviewed as key informants, or included in the Google forms-based interviews for frontline workers.
Non-response or delayed response to surveys for frontline workers.	The evaluation team sent out the Survey to as many people as could be identified in order to increase the chances of getting a reasonable number of responses that could provide valid and reliable results.

## 3. FINDINGS

### 3.1 Programme Impact on infant mortality and stillbirths

In this subsection, the assessment focuses on answering the following questions: **what was the impact on infant mortality and stillbirths that the programme had, and what facilitated or hindered its implementation (e.g. change in attitudes, overcoming tangible barriers, self-efficacy of women, working closely with health workers, etc.)?**

*What was the programme impact on infant mortality and stillbirths?*

Anecdotal evidence generated from interviews with programme participants, including women, men, health workers, programme implementing partners and district/woreda level health staff in both countries suggest that the programme interventions have resulted in positive impacts on maternal and child health, generally, and infant mortality and stillbirth, specifically.<sup>27</sup> In Goro, 8 in 10 of the health workers that were interviewed responded that there was reduction in infant deaths in their communities over the last three years. This reduction in infant mortality is attributed to expectant mothers’ attendance of ANC check-ups and giving birth at the health facilities, as testified to in interviews with a midwife in one health centre in Luuka,<sup>28</sup> several frontline workers that participated in the Google form survey, and women beneficiaries in Goro and Oyam.<sup>29</sup>

<sup>27</sup> Interview with a female beneficiary Fugo Oda Mela, Goro; Interview with a female health worker, Oyam; Interview with a female health worker Luuka district

<sup>28</sup> Interview with a midwife, Luuka District

<sup>29</sup> Interview with female beneficiary, Lemen Abu, Goro, Ethiopia; Interview with a female PLA facilitator, Myene, Oyam



The above finding was supported by the District Health Team in Oyam district, Uganda, which indicated that, based on the district information register,<sup>30</sup> infant mortality has decreased. Still, it is important to recognise that the number of neonatal deaths may be higher, since the only available data on neonatal death is that recorded at health facilities. It does not include deaths that occur at home. The MakSPH Project Report Year 2 indicates that there were reduced numbers of women dying in childbirth and that neonatal deaths have also decreased. The Verbal Autopsy/Social Autopsy (VASA) sessions conducted by the programme in Luuka district two years apart (2018 and 2020) showed a significant reduction in infant mortality from 200 deaths in 2018 to 90 deaths in 2020.<sup>31</sup> (See Story of Change 1.)

Data collected through interviews with district officials and zonal officials from the three programme locations shows that there have also been reductions in stillbirths. For example, the Oyam District Information System report recorded no stillbirth. The reduction in stillbirths was attributed to adequate sensitisation on available services and how to avoid maternal health risks associated with home deliveries. As a result, most women embraced the practice of delivering at the health facilities.

Interviews with community beneficiaries show that health-seeking practices among the targeted communities have improved, including child immunization, malaria prevention through use of nets, testing every mother for HIV to prevent mother-to-child transmission, all of which contribute to minimizing the risks of infant and child mortality, STI treatment, etc.<sup>32</sup>

A review of the MNCH indicators that were being monitored showed significant improvement, especially in ANC attendance, in the three programme locations. Mothers now start ANC visits as early as the first month of pregnancy.<sup>33</sup> In Oyam district the assessment shows that coverage of first antenatal visits (1<sup>st</sup> visit) had increased from 14% to 40%<sup>34</sup> although within the target sub counties the percentage of mothers of children aged 0-11 months attending 4 or more ANC sessions with a skilled provider during their most recent pregnancy had increased from 71% (2017) to 114% by end of October 2020.<sup>35</sup> For Goro the coverage of first antenatal visits (1<sup>st</sup> visit) had increased from 74% to 90% and for the 4<sup>th</sup> visit from 26% to 46%.<sup>36</sup> In Luuka district, a review of the end-line evaluation shows and increase in the percentage of women attending at least the 4<sup>th</sup> ANC visit from 65% to 73%.<sup>37</sup> This means that although there is a higher attendance of 1<sup>st</sup> ANC visit among the women in Goro compared with their counterparts in Oyam and Luuka, a lesser percentage complete the recommended 4<sup>th</sup> ANC visit in Goro. Data from HMIS shows that Oyam had a high rate of ANC 4<sup>th</sup> visit attendance rate.

Data also showed that there were increased facility deliveries (SBA) across the three programme locations, which effectively minimized the risks of stillbirths and neonatal deaths. In Oyam, in-facility deliveries (SBA) rose from some 94% to 113 and in Goro from 45% to 58%. In Luuka, the rate of institutional deliveries increased from 73% (baseline) to 91% (end-line).<sup>38</sup>

Data from the review of HMIS for Oyam and Goro and the end-line programme evaluation for Luuka shows that there has been a significant improvement in the PNC uptake in Goro and Luuka. In Goro, the PNC uptake has increased from 43% to 56%<sup>39</sup> and in Luuka from 46% to 62%<sup>40</sup> from Baseline to End-line respectively. In Oyam district PNC uptake stood at 43% at the end of September 2020.<sup>41</sup>

Data from interviews with various stakeholders in the three locations showed that the awareness and sensitisation conducted in Goro and Oyam through PLA sessions, and through video shows in Luuka, had led to increased uptake of prenatal and postnatal care and practices.

30 Key Informant Interview with DHT Oyam  
 31 Interview with a medical worker, Luuka district, Uganda  
 32 Interview with a female beneficiary, Lemen Abu, Goro, Ethiopia  
 33 Interview with a community facilitator, Myene Sub County, Oyam district, Uganda  
 34 Interview with NGO Worker in the Health Sector  
 35 WCF. 2020 HMIS Data Analysis Report  
 36 CUAMM. 2020 HMIS Data Analysis Report  
 37 MakSPH. 2020. COMONETH Evaluation report  
 38 MakSPH. 2020. COMONETH evaluation Report  
 39 CUAMM HMIS data analysis November 2020  
 40 MakSPH. 2020. COMONETH evaluation Report  
 41 WCF. 2020 HMIS Data Analysis Report

Mothers across the intervention locations have also been trained in strategies for protecting new-borns and premature babies. This training for mothers also contributed to improving their self-efficacy. The women that participated in the PLA sessions in Goro and Oyam and community sensitisation meetings in Luuka were making informed choices and decisions on seeking Reproductive, Maternal, New-born and Child Health (RMNCH) services. Increased knowledge regarding infant mortality and stillbirth, as well as mother and childcare in general, was reported in all communities in the three programme sites -- this includes knowledge about kangaroo method, nutrition awareness and support available to community members. Data from interviews with women beneficiaries from the three programme locations also shows that women were now aware of the importance of early preparation for delivery and diagnosis practices in preventing mother-to-child transmission, and of disease prevention, which has been a contributory factor to infant mortality.<sup>42</sup> The mothers interviewed knew the recommended strategies for prevention of malaria and for maintaining hygiene, and the importance of early preparations for delivery.

Year 2 programme reports from the funded partners showed that increased access to ANC led to an increase in uptake of information and services by expectant mothers, leading to a drastic reduction in maternal and neonatal deaths and stillbirths. In Goro, Oyam and Luuka the community beneficiaries concurred that, previously, many mothers used to give birth at home, and they were not motivated to seek professional help. Data from interviews with health workers and beneficiaries also show a hugely different behaviour in seeking medical follow-up for their new-borns.

There was also improvement in the referral system right from community level; this greatly contributed to the reduction in infant mortality and stillbirths. According to interviews with health workers across the three programme locations, the interventions in each of the three districts had supported the development of a functional referral system, which has been key in enhancing maternal health services<sup>43</sup>. In the case of Luuka district, the operationalisation of the theatre at Kiyunga Health Centre has had a great impact, saving about 30 mothers who received EmOC at the facility every month.<sup>44</sup>

Furthermore, as part of the strengthening of the health systems, the programme invested in training of health workers to enhance their capacity and equip them with modern practices in Reproductive, Maternal, New-born, Child and Adolescent Health (RMNCAH). The enhanced capacity of community health workers has increased the professionalism with which they treat clients and has generally improved their attitudes towards client care and service. This has enhanced the trust of the women and men seeking RMNCH services.<sup>45</sup>

### *What facilitated or hindered the achievement of impact?*

The achievement of impact has been facilitated by the following:

- ② Increased **knowledge** about causes of maternal and neonatal deaths and stillbirths, and how to mitigate the problems, as suggested by data from interviews with project beneficiaries and frontline workers across the three programme locations.
- ② Change in **attitudes and practices** about pre and postnatal care practices among women and men in the targeted communities, particularly among those who participated in PLA sessions in Oyam and Goro and in community sensitisation sessions in Luuka through video shows. This has led to improvement in care seeking behaviour among women. A majority of the women attend ANC and prepare early enough to ensure they deliver their babies at the health centres.
- ② The discontinuation of **unsafe practices**, such as use of Traditional Birth Attendants (TBAs), harmful umbilical cord care practices, bathing babies immediately after birth, negative nutritional practices, harmful traditional practices like female genital cutting of newly born babies, etc.

<sup>42</sup> Interview with a male respondent in Abok Sub County, Oyam district, Uganda

<sup>43</sup> Interview with Health In Charge, Acut HC, Oyam district, Uganda

<sup>44</sup> Interview with the medical worker, Luuka district, Uganda

<sup>45</sup> Interview with a beneficiary, Luuka district



- ② Improved access to **quality MNH services** by mothers and new-borns due to strengthened health care systems in the target areas. At the health facility level, the health workers have also **changed their attitudes** to work and were **more receptive** to expectant mothers, making the health care services more attractive to the latter. In addition, the health centres have more regular supplies of medicines and other essential medical commodities, thus ensuring they can offer effective services.
- ② The availability of **ambulance services** in the three programme locations enabled expectant mothers in need of emergency care to access health centres and hospitals for timely CEmOC services. The ambulance services are now offered at Kiyunga Health Centre IV in Luuka, at Aber Hospital in Oyam, and at St. Luke Hospital in Goro, Ethiopia.
- ② In Oyam district **the transportation voucher system and the Community Health Financing scheme** have also played a complementary role in enabling many households that would have otherwise found it difficult to access pre and postnatal care services.

Please refer to Section 3.6 for additional factors that have contributed to the successful implementation of the programme and achievement of impact.



### **Key Lessons learnt**

- ② Using innovative strategies to reach and engage with and sensitise communities in remote areas such as Luuka, Oyam and Goro can result in reductions in maternal, neonatal and infant mortalities and stillbirths. However, this engagement and sensitisation must also be accompanied with health systems' strengthening to ensure access and effective service delivery.
- ② In order to facilitate change, communities need the opportunity to openly discuss issues that affect them, such as infant mortality and stillbirths, and what they can do on their own to address the issues. This is what this programme has offered to the targeted communities. It has provided an opportunity and space for members to engage, discuss and take action to improve maternal, infant and child health in their communities. However, there was need for more time, for engagement with communities, and deliberate strategy to increase male involvement and youths in order to entrench the change in MNCH practices across all relevant population groups of the communities in the three locations.



## Box 2: Change Story 1: COMMONETH Project – The Game Changer

### COMMONETH PROJECT – The game Changer

*I have been involved in the project as a medical officer mainly responsible for providing emergency obstetric care for mothers in the in the COMMONETH PROJECT, stationed at Luuka Health Centre IV. I have worked with an Anaesthetist to provide the needed emergency obstetric care to referred mothers and babies at the Health Centre.*

*The employment of a doctor and Anaesthetist, health education, facilitation of VHTs with a small allowance, however little meant a lot to them, training of staff in mother and neonatal care, and support supervision by the COMMONETH project staff to health staff in their respective health centres has **contributed a significant change to maternal and child health in the district.** A district that does not have a hospital and the only health centre IV did not have a functional theatre to offer comprehensive obstetric care.*

*The project has had tremendous impact. To give you an example, **there were many neonatal deaths in the district. For instance, the first VASA that was conducted about 2 years ago (2018) indicated 200 deaths in that year. The VASA we conducted in the third year of the project indicated 90 child deaths.** Let's put it into another perspective. Before the project there were no C-sections that could be performed at the Health Centre. The Theatre was actually being used as a store. Every month we do about 30 C-sections. So one wonders what happened to the mothers that needed C-Section and could not afford to reach Iganga Hospital which is more than 30 kms away and on a bad road. Most likely those mothers died. Our being there has reversed the situation by about 95%. The project has been a game changer.*

*The project has tried some innovative strategies which have led to the success of this intervention. For example, the community education using the video shows in village video shelters provided a good opportunity to engage with the communities, sensitize and create awareness. The use of VHTs as change agents, and of course the VASA sessions which were engaging in assessing the causes of death of mothers and babies were other innovations. Communities began to appreciate the causes of death of their children and mothers and this inspired them to change their practices. I should add, all these strategies worked in combination to create success.*

*Even if the project has come to an end, the following will remain. The knowledge we have imparted and the skill will remain in practice. VHTs will continue working. Mothers will continue coming to our facility for ante-natal services because they have seen the benefits. Health education may continue in different forms.*

[narrated by the project medical doctor, Luuka district]

## 3.2 Most successful strategies in implementation of pre and postnatal care practices

In this subsection, the evaluation will answer the question: **Which strategies were the most successful in the implementation of pre and postnatal care practices and skilled delivery (including home care practices such as exclusive breastfeeding, skin-to-skin contact from birth, early onset of breastfeeding, ensuring babies are kept warm and ensuring basic prevention of infections) and why?**

A review of programme documents and interviews with the programme beneficiaries and other stakeholders revealed the following strategies as the most successful in the implementation of pre and postnatal care practices and skilled delivery.



### **Successful strategies in implementation of prenatal care practices**

**Disease Prevention:** The programme supported the health facilities with medicines and other medical supplies to ensure that mothers and babies were protected from health threats such as malaria, HIV, STIs, diarrhoea and other preventable diseases. In Oyam and Goro, mothers were given fansidar, a malarial preventive drug, and mosquito nets, and were trained in how to use the nets to prevent malaria.<sup>46</sup> In Goro, the PLA groups, with the help of HEWs and Woreda Health Officials, mobilised communities to clear areas that act as mosquito breeding sites, and sensitised them regarding the importance of clean environments. The communities were also sensitised to the importance of Indoor Residual Spraying (IRS).<sup>47</sup> Other disease control measures included provision of deworming tablets for mothers, screening for cancer, and testing for HIV and other STIs to avoid mother-to-child transmission. All these measures were provided free of charge in the target health facilities.

In Goro poor hygiene was identified during PLA sessions as one of the causes of diarrhoea. Seventy out of the 100 PLA groups made this a priority issue in their awareness-raising, along with promoting the construction of pit latrines so as to reduce open defecation practices.<sup>48</sup>

The VASA exercise in Luuka was very extensive and discussed the causes of death and how it could have been prevented.<sup>49</sup> Likewise, during the sensitisation sessions using film shows in the *Bibandas* some of the screenings showed sick children or mothers, and helped the participants to discuss and ask questions on how to prevent such diseases.<sup>50</sup>

Disease prevention strategy was successful because often the solutions were initiated through PLA sessions and adopted as action plans. The provision of free health supplies in government facilities was also key.

**Vaccination/Immunisation:** Awareness-raising on the importance of vaccination of expectant mothers and immunisation of babies was conducted across all programme locations. Data from interviews with various participants from the three target communities shows that vaccination of pregnant mothers and children as a preventive measure against disease was emphasised during the community awareness and PLA sessions. Vaccination was also successful because of the increased uptake of ANC and PNC services. In addition, the VHTs in Luuka and Oyam and HDAs in Goro routinely reminded mothers to take their children for immunisation. Vaccination was also a well-received health strategy because it is one of the measures most promoted by governments in both countries for the prevention of maternal and infant death due to diseases such as hepatitis B, tetanus, measles, polio and others. Moreover, immunisation of mothers and babies is a free service, and for expectant mothers it does not require an additional cost beyond that of attending an ANC session.

**Nutrition:** Interviews of programme beneficiaries showed that Goro and Oyam PLA groups prioritised nutrition as an important maternal and new-born and child health issue. They sensitised communities on nutritional practices for mothers and new-borns, and some of the PLA groups took "improving nutrition at a household level" as part of their action plans.<sup>51</sup> In the two programme locations, nutrition was mentioned strongly as a strategy that benefits all family members, prevents many diseases, including malnutrition and stunted growth among babies, and often did not come at an additional cost, since most of the important foods could be got at home. In Goro, many PLA groups adopted the growing of vegetables and cereals, rearing chickens for eggs, etc., as practices to improve household nutrition. Nutrition was, however, not mentioned a lot during community interview sessions in Luuka district.

**Antenatal care:** Antenatal care (ANC), is one of the maternal health practices aimed at preventing problems for mothers and unborn babies during pregnancy. The aim of ANC is to prepare the parents for birth and parenthood, as well as prevent, detect, alleviate, or manage the health problems during

<sup>46</sup> Interview with Oyam district Official, Uganda

<sup>47</sup> WCF & CUAMM (2020) Evidence for Decision-Making Report: Helping Mothers and Children Survive and Thrive in Goro Woreda, Ethiopia

<sup>48</sup> Ibid

<sup>49</sup> Interview with Community Health Worker, Luuka district, Uganda

<sup>50</sup> Interview with a VHT, Luuka district, Uganda

<sup>51</sup> Interview a female beneficiary Lemen Abo, Goro, Ethiopia; Interview with a female beneficiary, Abok, Oyam, Uganda; and Interview a female beneficiary Dibdibe Abado, Goro, Ethiopia



pregnancy that affect mothers and babies.<sup>52</sup> ANC was one of the most promoted practices by the programme across the three targeted locations. To ensure that more mothers attended ANC clinics, CUAMM in Oyam introduced a voucher system/transport subsidy, which indeed raised ANC attendance rates in the target health centres. Awareness-raising about ANC was also a key role of VHTs, HEWs and HDAs in the target communities.<sup>53</sup>

Data from interviews with mothers and health workers suggested that the reduction in maternal and infant deaths and stillbirths in the three programme locations was attributed mainly to the increased uptake of ANC by expectant mothers. The attendance of ANC clinics had, besides educating the mothers, helped to increase bonding between the expectant mother and the health workers (midwives and nurses), thus increasing health seeking practices and institutional deliveries.

### **Successful strategies in implementation of safe birth practices**

**Provision of mama kits to mothers:** In all programme intervention areas, mothers who turned up for ANC and for delivery at any of the programme supported health facilities were provided basic MNCH kits to assist in delivery. These included items like gloves, antibiotics and others. This attracted more mothers to embrace the practice of delivering at health centres.

**Skilled Birth Attendance (SBA):** SBA has become a popular and accepted practice among women in the targeted communities as a result of promotion activities. Interviews with community beneficiaries showed that the sensitisation through PLA in Goro and Oyam, and the *Bibandas* in Luuka, as well as the awareness-raising during ANC clinics, emphasised the importance of delivering in health centres.

Data from interviews with facility-based health workers showed that, after attending refresher trainings on patient care and other safer delivery practices, the midwives and nurses in the targeted health facilities across the programme sites exhibited friendlier and more responsive attitudes towards expectant mothers. This has led to more SBA deliveries in all three communities. In Oyam, the uptake of the service has become so popular that expectant mothers even go to Health Centre II<sup>54</sup> for assisted deliveries if they cannot make it to Health Centre III. Also refer to 3.4, and Annex 4. The programme has therefore also trained the Health Centre II staff in safe delivery methods, even if the facilities are not gazetted for deliveries.<sup>55</sup>

**Helping babies to breathe:** This is one very crucial strategy in reducing the number of babies dying during the first minute after birth. It comprises a set of proven neonatal resuscitation techniques that can reduce neonatal mortality by up to 47% and fresh stillbirths by 24%.<sup>56</sup> It has been emphasised during the sensitisation meetings in PLA in Goro and Oyam and *Bibandas* in Luuka, as well as during ANC sessions. Many mothers that participated in the interviews mentioned it as one of the reasons why they must have their deliveries at the health centres assisted by a skilled birth attendant. According to a midwife with experience in skilled delivery in Luuka district, helping babies to breathe was the most successful factor in increasing chances of new-borns' survival. He further noted that this success was mainly attributed to the involvement of VHTs in the training, because, as grassroots ambassadors, they relay information to the mothers and communities<sup>57</sup>. Data from frontline workers' survey supported this view.

### **Successful strategies in implementation of postnatal care practices**

**Exclusive breastfeeding:** In Goro, Luuka and Oyam, breastfeeding a new-born was found to be a common practice, unless the mother had certain health problems, such as HIV infection, tuberculosis, breast abscess, etc. Early initiation of breastfeeding was recognised as a popular and simple but very important practice in reducing infant mortality. However, before the intervention, the mothers did not fully know its benefits, such as protection against childhood illnesses. They did

<sup>52</sup> [https://www.who.int/pmnch/media/publications/aonsectionIII\\_2.pdf](https://www.who.int/pmnch/media/publications/aonsectionIII_2.pdf)

<sup>53</sup> Interview with a female participant, Bulongo sub county, Luuka district; Interview with a female participant, Denbeli Dilela, Goro, woreda, and Interview with a male participant, Bukoma, Luuka, district; and Interview with a female participant, Ngai sub county, Oyam district

<sup>54</sup> Although manned by trained health workers, HC II are not equipped to assist deliveries but they are the nearest to the communities

<sup>55</sup> Interview with a Health worker, Oyam district, Uganda

<sup>56</sup> <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/helping-babies-survive/Pages/Helping-Babies-Breathe.aspx>

<sup>57</sup> Interview with a Midwife, Bukanga sub county Luuka district, Uganda

not know the number of times, duration, and positioning of the baby while breastfeeding. Data from interviews with programme beneficiaries in Goro and Oyam showed they were more aware of the importance of exclusive breastfeeding because it was an issue emphasised during the PLA sessions. Data from interviews with men in Goro and Oyam districts showed that they developed interest and were supporting their wives in exclusive breastfeeding by ensuring that their breastfeeding spouses also eat well and spend more time with their babies.

**Delayed bathing of new-borns for 24 hours:** Delayed bathing of new-born babies is a recommended medical practice for preventing infections and helping the baby's blood sugar levels to stabilise. Women across the three programme locations were unaware of this recommended practice before the intervention. It was one of the key practices promoted among the target communities and monitored in all programme sites, especially amongst women who delivered outside health centres. Data from interviews with frontline health workers and VHTs found that this practice has not yet been fully adopted among mothers giving birth at home,<sup>58</sup> in part because even if the mother were aware of the need for delayed bathing of the new-born, during delivery she is not in control of the baby. Often the non-professional birth attendants are not familiar with the recommended practice. Thus, more effort is needed in this direction, especially keeping it on the PLA agenda and other community sensitisation forums in the target areas.

**Skin-to-skin contact:** Also known as kangaroo mother care, skin-to-skin practice is an important practice for enabling a baby to benefit from the warmth of the mother immediately after birth and improves bonding between mother and baby. The practice was promoted by health workers and used across the three intervention districts. It was recognised as a natural way of keeping children warm and safe. For mothers that adopted the practice, it also helped in initiating early breastfeeding.

Skin-to-skin was also cited as an important practice for premature babies who otherwise would need to be put in incubators, which are not always readily available or functional in rural health centres without access to electricity. While popular among women, the skin-to-skin strategy had challenges. For instance, in the case of premature deliveries, the beneficiaries cited time constraints on implementing the practice, as they were frequently engaged in outdoor activities like agricultural work,<sup>59</sup> and for working mothers it might be simply impossible to implement. However, apart from time, this was an effective strategy that required no cost. In the case of premature babies, mothers could also take turns with fathers.

**Saving money:** Most rural households are too poor to afford the cost of transport for ANC, delivery, and PNC, and more so if it is an emergency that requires an ambulance. Cost is one of the challenges that limits women from receiving ANC and PNC services and giving birth in health facilities across the three programme locations.<sup>60</sup> Data from interviews with beneficiaries in Goro and Oyam mentioned the importance of saving money right from the earliest stages of pregnancy, as a strategy for birth preparation. This would enable mothers to have safe deliveries at the health centre, as well as to care for their babies. In Oyam this is being done through the Community Health Financing (CHF) and Village Savings and Loans Associations (VSLAs), which have become popular complementary activities of most PLA groups in the district. Participants in the saving groups borrow from the groups to meet the transport costs and other needs, such as clothes for the babies, feeding and other associated costs. The majority of the PLA groups in Oyam had VSLA and/or CHF as part of their activities.

Overall, the evaluation has made the following observations about implementation of the most successful strategies and practices. These strategies have been promoted more among women than men, and women show more interest because they are more directly affected by maternal issues. However, it is important to focus on and encourage men to play a bigger and more proactive and supportive role. In Oyam, Uganda, and Goro, Ethiopia, men seemed to have become more interested in maternal health than their counterparts in Luuka district, Uganda. The men that participated in PLA sessions in Oyam, Uganda, and Goro, Ethiopia seem to have been more informed about these strategies and more supportive of their wives in practicing those strategies than their counterparts

58 CUAMM. 2019. Annual Report, Year 2, Goro, Ethiopia

59 Interview with a female beneficiary Otwal, Oyam district, Uganda

60 Interview with health worker, Oyam; Interview with a VHT in Luuka, Uganda

in Luuka district, Uganda. This is because PLA is more protracted and engaging, especially in prioritising and action planning, than VASA, which was used in Luuka and is more of an external-led event to discuss the problem and find the causes.<sup>61</sup> The sensitisation sessions in *Bibandas* in Luuka were also attended more by women than men.<sup>62</sup>

The strategies have been promoted among the target beneficiaries through community awareness sessions and PLA sessions, and home visits by HEWs/VHTs and HDAs. The latter are an important element in continuous engagement and awareness-raising in the community. They are also instrumental in following-up with mothers to ensure adherence to maternal and new-born health care practices that improve birth outcomes and survival for the mother and her baby. However, although the PLA sessions have been more effective than the general community awareness sessions and VASA, it is important to note that not every member of the community participated in the PLA groups. It is therefore essential that the VHTs, HDAs, and HEWs participate in PLA sessions, as this increases their knowledge base, and it promotes greater trust amongst the community members.

The more receptive the health worker is, the more the women will feel confident in visiting and seeking services. Thus, in addition to retraining health workers to increase their technical knowledge, it is important that other soft skills, such as patient/client attention, be promoted and recognised as paramount.

On the one hand, certain strategies such as the Kangaroo Mother Care for handling of premature babies were found not to be very commonly used among the beneficiaries interviewed, probably because these strategies were emphasised less or because communities were not adequately sensitised or trained in their application. Additionally, with the increased uptake of maternal health service, and the adoption of safe practices, there were fewer premature births. On the other hand, certain strategies could only be administered by professionals, such as helping babies to breathe. However, for the target population of this programme -- the rural women and men in Goro, Oyam and Luuka -- most of these strategies are feasible.

Some of the strategies were successful, but more time was needed for the communities, and especially the mothers, to be trained so as to ensure effective application of some of the strategies. More time is also needed to engage with men, in order to break the age-old gender/social norms that impede optimal male participation in MNCH.



### **Lessons learnt**

- ① The innovative approaches used, particularly PLA and tailored educational -entertainment videos, were highly effective in enabling the communities to learn about pre and postnatal care strategies. People were given ample time and space to understand these strategies and appreciate their importance in saving the lives of both mothers and their babies. Adoption of such innovative tools for public health education by the health sector can help in improving reproductive, maternal, new-born, child and adolescent health (RMNCAH) outcomes.
- ② Timely access to appropriate health services is an important aspect in reducing maternal mortality, infant mortality and stillbirths. The majority of the identified strategies that can improve MNH outcomes do not have a cost implication. All they require is attending ANC clinics and giving birth in a health facility. This must be done in a timely manner. However, whether free at the service end, there are transport costs involved that many poor rural households may not be able to afford. The economic barrier to access MNH services at health facilities is therefore a huge challenge. The programme tried solving this challenge by implementing an ambulance system across the three intervention locations. This is not sustainable with the low funding base of the healthcare sector. This challenge could be offset through a government-led health insurance system, such as a transport voucher system for expectant mothers, and self-help CHF schemes.

<sup>61</sup> Interview with a male participant, Fugo Oda Mela, Goro woreda, Ethiopia

<sup>62</sup> Interview with Health worker, Luuka district, Uganda

Box 3: Change Story 2: Learnt strategies to take good care of my child and myself

**Learnt strategies to take good care of my child and myself**

*I have been involved as a community facilitator. We were selected from the Kebele, those completed grade ten and had a family and child/ren. I got the information through the chairperson of our Kebele and manager. We were trained at Goro Health Centre for eight days and we were given the essential materials. Then we started educating the community along with Health Extension Worker, the project manager and the Kebele Administrators.*

*Previously children were affected a lot in our community. In this community there was high occurrence of infections, and female genital circumcision. The health centre, particularly the delivery room was not clean. The community did not use bed net at all in which Malaria was affecting them a lot. The hygiene in the community was very poor. Many homes in the community did not have pit latrines. Children were affected with diarrhoea.*

*After the first three PLA sessions, the PLA group members decided to change this bad situation. I went home to home with the health extension worker and help to fix up bed nets. Now women use bed net after delivery to minimize the risk of getting malaria themselves and their child. To improve child health and prevent diarrhoea the community decided to ensure that each homestead builds a pit latrine.*

*Previously men did not accompany their wives to the health centre, but currently this has changed. Some men are aware of the importance of taking their wives to health centre and why they should deliver at the health Centre. After delivery women also give care for their babies properly.*

*Previously many parents did not let their child to be vaccination but this has changed. Now children get vaccination up to nine months. This is big improvement. **Mothers are seeking health care service during pregnancy, giving birth at health centres, and taking their children for vaccination.** The community perceptions changed more after this project came to the community. Previously the health extension workers used to give health education but there is a huge change is seen after PLA sessions.*

*I learned on how to take good care of my child and myself. Soon after I gave birth, they let the **child on my chest (skin-to-skin)**. I feed my baby 8 times per day. I **breastfeed exclusively** him, with the proper handling method. I also go to the health centre to get family planning.*

Narrated by a female PLA Facilitator, Denbeli Dildila, Goro woreda, Ethiopia

### 3.3 Effectiveness of PLA Methodology

In this subsection, the assessment focuses on answering the following questions: **a) How effective was the PLA methodology in mobilising communities to participate in the programme, learn, and stimulate action on RMNHC issues in their communities? b) How well were the PLA meetings conducted? c) What were the challenges in conducting/participating in the meetings? And d) Which stages of the PLA meetings were difficult to implement?**

This programme has used a Participatory Learning and Action (PLA) approach to improve health outcomes of mothers and new-borns in Goro, Ethiopia and Oyam, Uganda. PLA methodology supports communities to come up with local answers to address the problems community members face. It engages community members concerned about these issues in groups and guides them through monthly meetings in a four-phase action cycle to: a) identify problems; b) identify local solutions to these problems; c) plan and implement these solutions; and d) evaluate these solutions. Local facilitators use discussion prompts, picture cards and other tools to stimulate discussion.<sup>63</sup> The full cycle is delivered through 14 sessions (meetings). Three of these meetings were planning meetings. See Annex 3 for the outline of the content covered in each meeting in the four phases.

<sup>63</sup> [https://static1.squarespace.com/static/5b2cea5e9f8770afe0868780/t/5b98469421c67c2e7962aefd/1536706198206/WCF\\_PLA\\_24072018.pdf](https://static1.squarespace.com/static/5b2cea5e9f8770afe0868780/t/5b98469421c67c2e7962aefd/1536706198206/WCF_PLA_24072018.pdf)

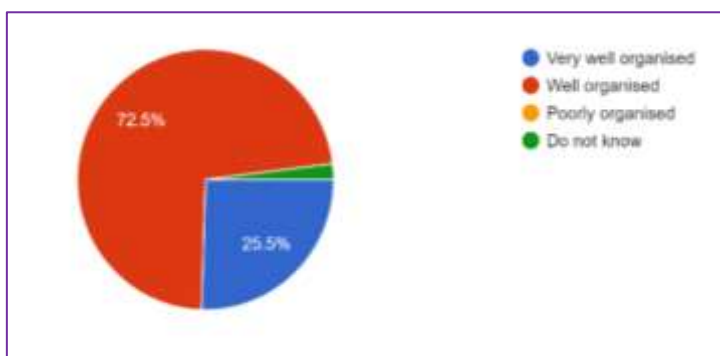


Women and Children First (WCF) took lead on guiding the implementation of the PLA methodology in both Goro woreda, Ethiopia and Oyam district, Uganda. A total of 210 PLA groups were formed, 100 in Goro and 110 in Oyam. The groups ranged from 40 to 100 members. Implementation of the methodology in both locations was similar except for the modification of the programme in Oyam to include adolescent health. In Goro, Ethiopia, there was one facilitator per PLA group, while in Oyam, Uganda each facilitator was responsible for two groups. WCF prepared a handbook, which the facilitators used in moderating the sessions.

How well were the PLA meetings conducted?

The PLA meetings in both locations were structured to follow a particular pattern. The PLA sessions were systematically organised through 14 sessions, with each session focusing on a specific topic and objective to be achieved. (See Annex 3). The meetings were moderated by trained facilitators from within the communities. Each PLA group decided on the frequency of the meetings and this varied from group to group. Some groups chose to meet once a month, while others met twice a month. In the initial meeting, members agreed on the ground rules and the meetings were conducted following PLA principles of equality, mutual respect, openness, democracy and equal participation. The members also agreed on the meeting venues, and where there was need for changes in the ground rules or any other decision this was done through consensus or democratically by voting. Group members often asked questions during and after sessions, for clarity and deeper understanding of the issues.<sup>64</sup>

Figure 1: How well were the PLA sessions conducted?



Data from interviews with participants in both Goro and Oyam shows that about 96% believed the meetings were well conducted by the trained facilitators. Data from interviews with frontline workers in support of this view show that, of the 51 respondents to the question, "How well were the PLA meetings organised?", 97% (n=50) indicated they were well organised. See Figure 1 below.

Interviews with PLA group members across the two countries suggest the following reasons to support the view that the sessions were well organised:

- a) The timing and scheduling of the sessions were agreed upon through a participatory process by the group members in the initial meetings.
- b) The sessions were facilitated by a community facilitator, selected from within the community, who was well trained in the methodology, and understood the issues of the community, and could also work with each participant’s learning needs as s/he led the processes. This made the task less daunting in terms of mobilisation and communication.<sup>65</sup> In addition to the community facilitator, the meetings were also well facilitated by trained, resourceful and well-informed persons, especially health workers, who often advised the communities on safe practices during and after childbirth. "The group used the same health workers who offer services at the facility to teach the communities making it easier to reach a large number as opposed to individual counselling".<sup>66</sup> This helped provide space for engaging on issues of maternal and child health in their community, including those that stemmed from the health facility, such as poor attitudes and work ethics of the health workers, lack of drugs, etc.
- c) The facilitators understood and used the local language and appropriate visual teaching materials, making the sessions practical and interactive, using role-playing, etc. This ensured that nobody was left behind.<sup>67</sup> Everyone participated, since the discussions were made easier

64 Interview with a female respondent Ngai sub county, Oyam, Uganda

65 Interview with a male beneficiary, Myene S/C, Oyam, Uganda

66 Interview with Health Assistant, Oyam, district, Uganda

67 Interview with a health worker, Ariba Subcounty, Oyam, Uganda; Interview with female beneficiary Goro, Ethiopia



by the community facilitator and were conducted in the local language. The facilitators were consistent, had good rapport with the learners and exhibited a lot of passion for helping their communities.

- d) Attendance of the sessions, after the initial three meetings, became more regular, consistent, and generally had a good percentage of attendance. Most meetings/sessions led to an agreed course of action that was reached through discussion.

### Which stages of the PLA meetings were difficult to implement?

The most difficult stage of the meetings to implement was the starting point of the exercise with involved mobilising members to meet and agree on the process, as some members did not follow time and others came from great distances. There was no specific facilitation for mobilisation, making it rather difficult for the group leaders, who often tried, on their own, to devise means to ensure all members attended. In cases where mobile phones were used to communicate with members, there were challenges with insufficient airtime and with the fact that not all members owned or had access to mobile phones. Additionally, the participants were not yet convinced about the rationale of the activity. This stage was mentioned as the most difficult by a majority of the participants across the two locations – Oyam and Goro.

The second, but probably equally most difficult stage, was the 8<sup>th</sup> stage. Like the 1<sup>st</sup> stage, stage 8 required another round of mobilisation of all community members for the PLA group to provide feedback, discuss the priority maternal and neonatal health problems in the community and identify solutions to address these problems. The meeting was also used to gather ideas and opinions of the whole community on the issues discussed by the group and solicit support from the whole community for the implementation of the group solutions.

The other difficult stages to implement were stages 9 and 10. These involved getting the people to mobilise funds and other resources to implement actions. This difficulty was more pronounced in Goro than Oyam. In Oyam, participants who were also part of the saving groups could borrow or use part of their savings to make their contributions. In Goro, because of the difficulties in mobilising resources to implement action plans, some facilitators or group chairpersons found themselves contributing their personal money to the action plans, such as construction of traditional ambulance. During these stages, the members in Goro started requesting and demanding contributions from the programme and the government to the community action plans.<sup>68</sup>

### What were the challenges in conducting/taking part in the meetings?

The following challenges in conducting/taking part in the meeting were identified by participants in Oyam and Goro.

- ② During the initial stages of the programme, some community members reacted negatively to the programme and showed a lack of interest in the programme activities. It took a lot of effort to convince such individuals to participate. With time and with a lot of sensitisation, a majority were successfully mobilised and began to appreciate the significance of the PLA engagement in helping their communities contribute to improvements in maternal and child health and that of the community in general.
- ② In Goro, there was also delay in initiating the sessions due to mobilisation challenges at the start of the intervention. Consequently, a number of the groups could not complete the 14 sessions by the time the Government of Ethiopia announced the COVID-19 lockdown. In Oyam, Uganda all the 110 PLA groups completed the sessions. In both programme locations, due to bad weather, especially rain, some sessions were cancelled and had to be repeated.
- ② There was also late-coming and absenteeism which led to inconsistency in learning, with the absentee members missing content on certain topics. Tardiness was a challenge because it would lead to delays in starting the sessions or to unnecessary recapping to allow the latecomers to catch up to the session. Absenteeism of some members of the groups in Goro arose from a variety of pressures, including scheduling conflicts between the meeting and

<sup>68</sup> Interview with a female PLA facilitator, Denbeli Dilela, Goro, Ethiopia

other previously arranged meetings/activities -- such as the "Edir" and "Iqub" meetings<sup>69</sup> in Goro; lack of time on the part of the participants, especially women and, in some cases, denial of permission by spouses to attend meetings; household chores, and farming (in both Goro and Oyam).<sup>70</sup> As a result, groups decided to meet once or twice a month, but also in the case of Goro to lobby kebele leaders and militias to enforce attendance of meetings. In addition, participation was also affected by seasonal changes. For example, during the planting and harvesting periods (summer and winter), most members of the community would be busy and hence there was less participation in programme activities and PLA sessions.<sup>71</sup>

- ② Failure to involve health staff in all the sessions as learners. This sometimes left a vacuum in the health staff's learning process, as well as in the community members' learning process.<sup>72</sup>
- ② High monetary and material expectations by some members of the community was also another challenge. Although cited in both countries, the issues of remuneration, participation allowances, transport refunds were more frequently mentioned in Goro than in Oyam. Generally, the communities (both Goro and Oyam), were used to such programmes funding community initiatives or even providing handouts, inputs or cash. In the case of Oyam, due to the more than 20-year-old insurgency in Northern Uganda, the population had grown used to handouts. A programme that expected voluntary contribution without reciprocity, therefore, led to disillusionment and some members lost interest and started to drop out.<sup>73</sup>
- ② Difficulties in accessing meeting venues by vulnerable members of the community, especially people with disabilities. Even when they were able to access the venues, they could not always participate fully in the activities given the limitations caused by the environment and/or the challenges of their impairments.<sup>74</sup>
- ② Environmental challenges. In Oyam, it was due to poor access roads, especially during the rainy seasons, as some roads became impassable when swampy sections flooded, leaving no option for the community members who would have to cross through swamps on foot or use rudimentary boats.<sup>75</sup> Likewise, in Goro, flooded rivers impeded participation during summer.<sup>76</sup>
- ② Although mentioned by one participant, the topic of MNCH presented some concepts that were very difficult to break down so they could be readily understood, especially by the men.<sup>77</sup> This led to diminishing interest. However, a general lack of interest amongst men was cited across the two countries as a big challenge.
- ② In Oyam, many facilitators that were interviewed mentioned the vastness of some villages represented a challenge when two of them had to be covered by one facilitator.
- ② In Goro the kebele leaders were not cooperative,<sup>78</sup> because most of the male kebele administrators were apathetic to women's issues.<sup>79</sup> In addition, it took time to mobilise and bring on board members of the Women's Development Army (WDA) and this delay was perceived as a lack of endorsement of the programme by WDA.<sup>80</sup> Likewise, in Oyam, the limited participation/involvement of sub county and district leaders left the community members doubting their district and sub county leadership's commitment to the programme.<sup>81</sup> However, with time, the commitment of WDAs in Goro and sub county leaders in Oyam was secured and they learnt to appreciate the importance of PLA as a good

69 Edir" is a traditional way of money contribution. The money is given to a family that has lost member during the mourning period. "Iqub" is also a traditional way of money contribution. The money is given to the members in turns (rotational), most of the time lottery method is used to identify the person who takes the money

70 Interview with female beneficiary Abok Sub county, Oyam, Uganda; Interview with a Community Health worker, Dambi Kono, Kebele, Goro, Ethiopia

71 Interview with a male participant, Goro, Ethiopia

72 Interview with Acut Health II staff, Abok Sub county, Oyam, Uganda

73 Interview with a district official, Oyam, Uganda

74 Female beneficiary Abok Sub county, Oyam, Uganda

75 Interview with a female beneficiary Otwal Sub county, Oyam, Uganda

76 Interview with, female beneficiary, Lemen Abu, Goro, Ethiopia; and Interview with Kebele official, Chancho Soyoma, Goro, Ethiopia

77 Interview with a female facilitator, Oyam

78 Interview with a female facilitator Abado Bukasa, Goro, Ethiopia

79 Interview with female facilitator, Gurura, Goro, Ethiopia

80 Female participant Denbeli Dilela, Goro, Ethiopia

81 Interview with a PLA facilitator, Oyam, Uganda

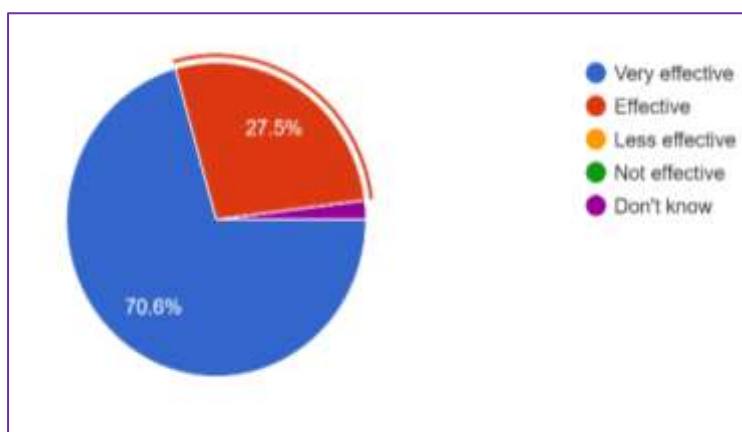
mobilisation tool, not only for the community, but for their government to engage on MNH issues.

- There was also limited representation and participation of men in PLA activities in Goro compared with Oyam. This could be because the PLA groups in Oyam had a very strong VSLA component.<sup>82</sup> The savings and credit activities are more attractive for men.

Overall, in spite of the mentioned challenges absenteeism and tardiness, owing to various reasons, including competing activities, seasonality, and social norms, the attendance figures within both programme areas were generally good.

How effective was the PLA methodology in mobilising communities to take part in the programme?

Figure 2: Effectiveness of the PLA methodology



The PLA methodology was employed by WCF and CUAMM in the Goro and Oyam projects to mobilise communities to effectively participate in the programme activities in their areas. Interviewed local leaders, health workers, community members who participated in the PLA sessions consistently suggest that the PLA methodology was effective in mobilising communities. Ninety-eight percent (n=50) of the frontline workers (largely health workers) that participated in the evaluation

from Goro and Oyam indicated that the PLA methodology was effective in mobilizing communities to take part in the programme, to learn and stimulate action on RMNCH in their communities. In Oyam and Goro, the programme interventions at the community level were all done through the PLA group activities.

To demonstrate how effective the PLA methodology was in community mobilisation, the district and sub county leaders in Oyam also found it easier to operate through these groups to mobilise communities to participate in government development programmes.<sup>83</sup>

Interviews with the programme beneficiaries and funded partner staff in the two locations also showed that in spite of the challenges in mobilising and organising PLA sessions, it was an effective approach for mobilising different members of their communities and their leaders to discuss MNH issues in a community led process.<sup>84</sup>

How effective was the PLA methodology in promoting learning, and stimulating action on RMNHC issues in their communities?

The PLA methodology has been effective in promoting learning. It provided a platform for awareness and sensitisation of the communities regarding existing services and strategies to enhance maternal and child health. Among others, issues of nutrition, breastfeeding, and disease prevention were discussed, and communities adopted these practices, leading to improved RMNCH outcomes.

For communities with relatively high levels of illiteracy among the rural populations, PLA methodology was effective in enabling learning among adults. This is because PLA relies on use of visualization through pictures, posters, role playing and demonstrations.<sup>85</sup> PLA encourages peer learning, and thus the learning extended beyond the sessions.<sup>86</sup> The communities became an extension of classrooms for continuation of learning. Even those who missed a session would get an

<sup>82</sup> Interview with a participant from district level official and gender expert, Oyam, Uganda  
<sup>83</sup> Interview with a District official from Community Development Department, Oyam District, Uganda  
<sup>84</sup> Interview with a female PLA facilitator, Gurura, Goro, Ethiopia; Interview with a female PLA facilitator, Otwal, Oyam; Key Informant interviews with CUAMM staff, Oyam  
<sup>85</sup> Interview with a female participant, Goro; Interview with a female participant, Ngai sub county, Oyam district  
<sup>86</sup> Interview with a female participant, Otwal sub county, Oyam district

opportunity to learn from peers who had attended. A participant from Oyam summed up her learning experience thus:

*"Being in a group provided a better learning and sharing opportunity as community members would easily extend knowledge acquired to others in their daily interactions. Further still social cohesion was established making members accountable to one another".<sup>87</sup>*

Data from Oyam and Goro however suggests that in Ethiopia the PLA group facilitation and learning was better and more structured than in Oyam. For instance, the PLA group members and facilitators who participated in the interviews had a better understanding of the PLA phases and sessions. They had a fairly better recollection of what transpired at each stage, the challenges encountered and how they overcame each challenge before proceeding to the next stage. This was not the case with their counterparts in Oyam. The PLA groups in Goro seemed to have a better grasp of the content, prioritisation of the issues and what was needed of them than their counterparts in Oyam.

Regarding PLA's effectiveness in stimulating action on RMNHC issues in their communities, data from the participants suggests that PLA sessions were effective in enabling communities to identify maternal and child health problems and their underlying root causes. Some of the identified problems include: poor feeding habits, malnutrition, malaria, failure to breastfeed, failure to attend antenatal clinics, and failure to deliver at health centres. Others are poor hygiene, challenges with transport and access to the health centres, poor health-seeking behaviour, poor/demoralising attitude and behaviour of health staff at the health centres, and failure of parents to have their children immunised. Out of these identified health and other related problems, using PLA tools, PLA groups in Goro and Oyam were able to analyse the problems and prioritise the ones they would engage with and tackle during the life span of the programme.<sup>88</sup> Based on the prioritised list of problems to tackle, the PLA groups, together with their communities, developed action plans that they have been implementing. This has contributed to the positive MNH outcomes/changes within their communities.<sup>89</sup>

In situations where they needed external support, PLA groups invited and then presented their issues to the sub county/kebele and district leaders for their intervention. Such constant interface and feedback to the district yielded positive responses. For example, in Oyam, the district recruited and posted more midwives to a number of health facilities where a critical need was identified. A few Health Centre IIs have also been elevated to Health Centre III level in response to the concerns raised by PLA groups as well as the assessment of the district health planning team.

Although RMNCH was at the core of the learning agenda of PLA groups in Oyam most of the groups added VSLA activity and CHF to their agenda to enhance solidarity and a spirit of self-help among the group members. This makes the groups more sustainable, as it enables the participants to generate their own resources through savings to meet their health needs and other needs. In Goro, most of the groups remained focused on the RMNCH agenda and, as a result, mobilising resources for implementing their action plans was a challenge. The evaluation has found the emerging Oyam PLA model more sustainable. Because, beyond the programme period, the groups still have a common and compelling goal that brings them together to continue meetings, which is an important opportunity for continued learning. Partners in the programme, like DHO or any other party, including CUAMM, that still have interests in the district can continue engaging with the groups to promote or pursue their common agenda.

Overall, the assessment has revealed that the PLA methodology was effective in mobilising communities to participate in the programme in Oyam and Goro (although with disproportionate challenges). The assessment has revealed that PLA was an effective tool for community sensitisation. Community members were empowered through this process of engagement with the duty bearers. Data from interviews with PLA group suggests that community members that participated in PLA sessions show a deeper knowledge and understanding and more positive attitudes and practices

<sup>87</sup> Interview with a female beneficiary Otwal Sub county, Oyam district

<sup>88</sup> Interview with a female PLA facilitator, Oyam, Uganda; Interview with a female participant Denbeli Dilela, Goro, Ethiopia

<sup>89</sup> Interview with District Health official, Oyam district, Uganda

regarding RMNCAH and increased health-care seeking behaviour. One participant summarised the effectiveness of the PLA methodology succinctly:

*"Our method of mobilization was successful. The sessions were convincing, satisfactory, and understandable to the community which helped us to get the attention of the community. The community also understood us and was ready to put what has been learnt into practice".<sup>90</sup>*



### Lessons Learnt

- ① PLA as a learning approach should be owned and driven by the group members at their pace. It is very difficult to fit it in specific timed sessions. An attempt to fit it into specific sessions risks curtailing in-depth discussion of the emerging issues and agreeing on solutions. It is better to allow a free-flow of sessions and implementation of solutions. That way the members will feel they have full control of both the process and the outcomes.
- ② Another lesson is that PLA can provide an alternative source of vital data on issues such as maternal, neonatal and infant mortality in areas where there are weak systems for monitoring and reporting such data. It is possible to use PLA groups in their respective kebeles and sub counties to collect reliable quantitative information on a monthly basis that can inform planning, as they know their locations, households and occurrences, such as births and deaths.<sup>91</sup>
- ③ PLA was expected to draw different population groups and engage them in RMNCAH issues. The hope was to engage women and men of all ages, and youth and, in particular, to target men and elderly women. Discussions with different groups showed that men and elderly women and youth of child-bearing age were not optimally engaged in PLA activities. The reasons are varied. The programme design dictated lesser numbers of men and youth compared with the women. The other cited reason was that since the subject was RMNCAH, this dissuaded men from joining, as it is considered a women's issue. **For the youth, they have different interests and need a different kind of strategy – youth friendly activities – hence, PLA was not for them. Yet, while issues that affect them, such as the effects of FGM and early marriages, came up during PLA sessions in Goro and Oyam, they were not given the attention they deserve. The elderly women would need support to reach the meeting places, but they are also the custodians of traditions, some of which contradict RMNCAH practices. Thus, they, too, need a different strategy for engagement.**

<sup>90</sup> Interview with female participant, Ngai subcounty, Oyam district, Uganda

<sup>91</sup> Interview with a district official in Oyam district, Uganda

## Box 4: Change Story 3: Effectiveness of PLA approach

**Effectiveness of PLA approach**

The Chairman of our kebele selected me and a health extension worker and trained for eight days as a PLA facilitator. The training used visual aids – pictures and illustrations that plainly show maternal and child health problems that take place during pregnancy and childbirth. On completion of the training, we were given training materials including diagrams/pictures and a manual that we use to teach the PLA group members in our kebele.

PLA was effective because women were deliberately selected to lead the discussions. This helps the women discuss freely among themselves any issues they come across. I think selecting women as facilitators brought significant change which also brought a sound result. As to me, I am afraid and was not comfortable going to health facility to give birth. Even though I follow pre-natal check-ups throughout my pregnancy period, I preferred giving birth at home. But, from the PLA discussion, **I learnt the importance of going to the health centre for delivery.** Nowadays, in our community majority of women give birth at the health centre. Female circumcision and uvulectomy have been abandoned because through the PLA discussions, we learnt of negative effects of these practices on mothers and the baby girls.

However, PLA has challenges. As we are mainly farmers in our community, **there are seasons when women work on the farm and can't attend the PLA meetings. In addition, women are always busy with other household chores and childcare work.** In my group we meet early morning for discussion and get back home early. The other challenge was, **during rainy season we couldn't not have a place to gather and sit to discuss as we meet outdoor.** During the **time of harvest there our sessions were interrupted for two months because the members were busy harvesting their produced.**

**The stage at which we had to put into action the solutions we had agreed as a group was difficult for us.** It was very difficult to collect the needed materials altogether. A lot of work had to been done to address the health problems that the community prioritized. These are malaria, diarrhoea and obstructed labour. We distributed mosquito nets. We also made traditional delivery bed. the other difficult stage evaluation stage where we had to present to the community members, because for me the work done was not satisfactory.

One thing our community learnt was prioritizing health problems then find ways how to address the problem. Nevertheless, PLA has been a great success for this community.

Female participant, Chirecha Tadra Kebele, Goro Woreda, Ethiopia

### 3.4 Referrals, skilled care and influence on district management systems

In this subsection, the evaluation will focus on answering the question: **Was there an increase in referrals to health facilities and improvement in skilled care during labour and birth, and how have these changes informed the district management systems?**

#### Increase in referrals to health facilities

The referral system in Uganda starts with VHTs as the first point of call, providing first aid services and referrals to a Health Centre II -- which is an aid post managed by 3 staff -- or to a Health Centre III, which can provide ANC and PNC, as well as basic emergency obstetric care (BEmoC) services. The Health Centre III employs at least a midwife and a clinical officer, has a labour ward and handles normal vaginal deliveries. Any cases of women whose deliveries are assessed to be complicated and require attendance of a doctor are referred to a Health Centre IV or a district hospital, as these can offer comprehensive emergency obstetric care (CEmoC) services. Often CEmoC services are not offered at the Health Centre IV because of factors such as lack of a functional theatre, or inconsistent electricity supply, or even absence of a doctor. Therefore, most Health Centre IIIs refer to the nearest hospital. In the case of Oyam district, the nearest hospital is Aber Hospital, situated in the



southern part of Oyam district and is managed by CUAMM. In Luuka district, before the programme, referrals were made to Iganga Hospital since there is no hospital in the district. Under the programme, therefore, Kiyunga Health Centre IV, which is also the only Health Centre IV in the district, was supported to have a functioning theatre and an obstetrician and anaesthetist to offer CEmoC services. (Also see Annex 4 on the health care system in Uganda).

In Ethiopia, the system starts with the **health post**, which is staffed and managed by HEWs who provide basic healthcare services. These then refer to the **health centre**, which is managed by conventional medical staff including doctors, midwives and nurses and can offer normal vaginal deliveries. These refer to the Primary Hospital, which is at woreda (district level) level, for CEmoC services. In this case, the programme supported St. Luke's Hospital at Wolisso to handle all referrals for CEmoC services emerging from the 16 health posts and 4 health centres. (Also see Annex 4 on the health care system in Ethiopia).

Data from interviews with frontline health workers, VHTs and HEWs from the three targeted locations suggests that there has been an increase in referrals for ANC, health facility deliveries and PNC during the programme life time. A review of programme documents from the funded partners shows that in Goro, by the end of year 2, the percentage of women with major obstetric complications who were referred and treated in a health facility providing EmOC in the previous 12 months had increased from 18% at baseline to 26.4%.<sup>92</sup> In Oyam, during the same period, the number had increased from 29% to 40%.<sup>93</sup> Likewise, the percentage of mothers of children aged 0-11 months assisted by a skilled birth attendant during their most recent delivery had increased from 67.9% to 77.1% in Goro, while in Oyam it had increased from 85% to 91%. In Luuka, the report indicated "increased referrals of pregnant women from the community to facilities by trained community health workers". However, interviews with health staff at Kiyunga Health Centre IV and the District Health Team revealed that the health centre had registered an increase in referrals from lower health centres in the district for CEmoC services. Every month there were about 30 C-sections being done at the Kiyunga Health Centre IV.<sup>94</sup>

The health workers interviewed attributed the increase in referrals mainly to VHT and HEW structures in the two countries, which the programme had revitalised and were thus very dynamic in referring mothers. The VHTs and HEWs conduct routine pregnancy mapping and monitoring and follow-up. They also systematically refer expectant mothers to the health facilities.<sup>95</sup> This has increased referrals, and deliveries at the health centre had increased.<sup>96</sup> One participant noted:

*"the VHTs have been very instrumental in educating mothers at grassroot levels on the need to seek health care, this has increased the numbers of mothers attending both antenatal and postnatal care. It is now quite rare for women to give birth at home".<sup>97</sup>*

Another factor that has led to increased referrals across the three target locations is the ambulance system. The programme facilitated the acquisition of ambulances in each of the three locations to transport women and/or new-borns that need CEmoC services within or outside the programme target district. The programme implementing agencies stationed the ambulances at strategic health centres - Kiyunga Health Centre for Luuka; St. Luke's Hospital, Wolisso for Goro; and Anyeke Health Centre IV and Aber Hospital for Oyam. From these centres, they responded to emergency calls for evacuation. This has led to an increase in referrals at different health centres. For example, referrals received at Ariba Health Centre, Oyam district have almost doubled from an average of 25 to between 40 and 50 mothers per month.<sup>98</sup> In Luuka, Kiyunga Health Centre receives about 30 referrals for C-Section alone.

Improvement in skilled care during labour and birth

92 CUAMM/WCF Year 2 project report, Goro  
 93 WCF/CUAMM year 2 project report, Oyam  
 94 Medical Officer, Luuka, Uganda  
 95 Interview with a PLA facilitator, Abok, Oyam, Uganda  
 96 Interview with a health centre III in charge, Luuka, Uganda  
 97 Interview with a health worker, Luuka, Uganda  
 98 Interview with Health Worker, Oyam, Uganda



Improvement in skilled care during labour and birth was assessed in two ways; first, in terms of deliveries assisted by skilled birth attendant, and second, improvement in services offered to mothers and babies during labour, birth and immediately after birth.

Skilled care during labour and birth refers to the process of giving birth under the care of a skilled health care attendant such as a nurse, midwife or doctor. A review of the programme reports and interviews with health workers across the three sites shows that, since the start of the programme interventions in Goro, Oyam and Luuka districts, there is improvement in skilled birth attended deliveries. In Goro, by the end of year two, deliveries by SBA had increased by 9%, from 68 at baseline to 77%, and in Oyam from 85 to 91%. In Luuka, deliveries in health facilities had not registered any increase compared with Oyam and Goro. This was attributed to likely flaws in the baseline data used. Anecdotal data, though, shows that there has been increase in health facility deliveries.

The above noted increase is supported by data from interviews with all 65 health workers that participated in the evaluation. Asked whether the quality of services offered to women and children at their local health facility had changed since the implementation of the programme, about 90% of the participants (women and men) across the three programme locations reported that there was improvement. See Table 7 below.

Table 7: Satisfaction levels with quality of MNH services

District	Yes	Somehow	No	Not sure
Goro	21	2	5	0
Oyam	10	-	-	1
Luuka	40	-	-	-
Total	71	2	5	1

Data from interviews with beneficiaries also shows that more women were seeking health service deliveries because of the sensitisation they had received about the risks of home deliveries during PLA sessions in Goro and Oyam and the sensitisation in the video halls and VASA sessions in Luuka. Additionally, the mothers were attracted to deliver at health centres because the staff at the health facilities were more receptive than before the intervention. The vigilance of the VHTs and HEWs in reminding and following-up with expectant mothers, and the free services offered at the health facilities, such as mosquito nets and delivery kits (mama kits), were added incentives. Availability of the ambulance and/or transport vouchers that enabled expectant mothers to reach the appropriate health facility also contributed to the increasing number of health facility-based deliveries.

Data from interviews with beneficiaries also shows that services at most of the health centres under the programme had improved because the health staff were more receptive and friendlier than they had been before, when they were often rude and abusive. In some health centres in Luuka and Goro, interviewed beneficiaries and health workers indicated that mothers in labour were even served tea/coffee.<sup>99</sup> There was dedicated staff to immunise the children. The midwives were also always available at the health centres to attend to the women in labour and during birth.

Furthermore, data from interviews with frontline health workers and beneficiaries showed that the quality of care offered at the majority of the targeted health centres in Goro, Luuka and Oyam generally improved. The facilities were cleaner;<sup>100</sup> the beds had mosquito nets to protect both the new-borns and their mothers; when there was need for lab services, the laboratories were functioning, and medicines were also more readily available than before.<sup>101</sup> The facilities were lit and those without access to the main electric grid were solar powered.<sup>102</sup> They also attribute the

99 Interview with a midwife, Luuka, Uganda; Interview with a female beneficiary, Abado Bukasa, Goro, Ethiopia

100 Interview with a female beneficiary, Chirecha, Goro, Ethiopia

101 Interview with a female beneficiary, Dibdibe Abado, Goro, Ethiopia

102 Interview with male participant, Fugo Oda Mela, Goro, Ethiopia





improvement to the refresher training given to the health staff, especially midwives; and the posting of additional midwives at health centres.

However, a few – 18% (n=5) -- of the interviewed beneficiaries in Goro indicated that the quality of services at their health centres had not improved and they cited three reasons, namely: the health staff at their specific health centres were not receptive to the women seeking the services at the health facility; the staff had negative attitudes, and the facility was not clean.

### How has increase in referrals and improvements in skilled care and birth informed the district management systems?

The increase in referrals and improvements in skilled care and birth has influenced district management systems in the following ways.

Interviews with health workers and district health teams revealed that, because of increased referrals that created greater workloads at health centres, the districts, particularly Oyam, recruited and posted more midwives and nurses to ensure effective delivery of MNH services.<sup>103</sup> (See Section 3.3 above).

The increase in referrals and improvements in skilled care and births influenced Oyam and Luuka districts to support some health centres with more equipment, such as delivery beds, and other basic equipment. It has also led to improvements in essential drug supplies.<sup>104</sup> In Luuka, the response included revamping the Kiyunga Health Centre IV to enable it to provide CEmoC services.

There is improved surveillance, information sharing and reporting which informs district planning and reporting on Health Management Information as well as response to the needs of the health centres.<sup>105</sup> This has contributed to Luuka's qualifying for the 'Result Based Financing', which has in turn increased funding for health facilities.<sup>106</sup>

In recognition of the importance of the ambulance system in increasing referrals of expectant mothers for skilled care during labour and delivery, Oyam district took over the maintenance of the two ambulances.<sup>107</sup> Although this has been erratic due to shortage of funds, prompting the programme to step in occasionally to meet the shortfall, the district has put in place a funding mechanism to ensure that there are always funds for running and maintenance of the two ambulances.<sup>108</sup>

Furthermore, increased referrals in Oyam district exerted pressure on the existing Health Centre IIIs before the start of the programme. This has prompted the district management to elevate Health Centre IIs in some sub counties, such as Abok, to Health Centre III level.<sup>109</sup>

Data from the three programme locations showed that the district health management teams had increased their routine monitoring and support supervision of the target health centres, to address any challenges emerging from increased referrals, while also offering on-the-job-training for staff in the health centres.<sup>110</sup>

Overall, the analysis has shown that there is an increase in referrals across the three programme locations. There are also improvements in the provision of skilled care in prenatal, birth, and postnatal care. The increase in referrals and uptake of MNH services at the target health centres has informed the district health management systems including staff recruitment, surveillance, monitoring and support supervision. However, there were still challenges in a few health centres in Goro, where quality service remains lacking. This may require CUAMM to investigate why change has eluded some of these health centres.

103 Interview with member of the District Health Team, Oyam, Uganda

104 Interview with Clinical officer, Luuka district, Interview with District level Health worker, Oyam, Uganda

105 Interview with CDC expert, Goro; Interview with a Community Health worker, Oyam

106 Interview with a member of the District Health Team, Luuka

107 Interview with CUAMM Programme staff, Oyam, Uganda

108 Interview with a district health official, Oyam

109 Interview with a Clinical Officer, Oyam, district

110 Interview with Woreda Health Office official, Goro; Interview with a member of DHT, Oyam



## Lessons Learnt

- The major lesson learnt is that for the intervention to influence the government management systems at any level, the relevant government structures must be involved throughout the entire intervention process, from planning and implementation through to reporting and monitoring processes.

### *Box 5: Change Story 4: Improved staffing and service provision*

#### **Improved staffing and service provision**

*I am a trained health worker aged 30 in Abok Sub County, Oyam district. I fully participated in the maternal and child health (MCH) project from the time CUAMM introduced it in our community working through the health centre.*

*When I started working at the health centre **my major concern was the poor structure and limited human resource. For example, we had only one midwife.** The volume of work kept piling but I continued wishing for another staff to be recruited.*

*Working in collaboration with the project staff and communities we identified this dire need for an additional staff given the high attendance at the facility. **Together we requested the for additional health workers. Consequently, a midwife was posted in May and another one in the month of September. In all the centre now boasts of three (3) midwives.** Though not directly attributed to the advocacy efforts of the communities, a Laboratory technician and a clinical officer were also recruited and posted to the health centre. **With improved staffing we could now conveniently conduct community integrated outreaches which in turn encouraged more women to turn up for Antenatal Care (ANC) and delivery at the facility. The women also encourage each other to go for skilled care at the facility having realized the benefit.***

*I could rightly deduce that the above factors resulted into increased facility deliveries, reduced infant and maternal mortality and generally improved health care in this community. Moreover, the community is now more informed about available services at the facility beside being equipped with knowledge about maternal and child health in general.*

*I am also grateful to the district authorities for the improved collaboration and working relationship. We can now bring together political leaders to help address some health challenges in our community. Together we mobilize the population to attend health care at the facility. In the past we had mothers resorting to traditional birth attendants (TBAs) because they were ignorant and feared to access health facilities. This has changed given the project intervention and most importantly the improved relationship between the health centre and the community members.*

Compiled by Dinah Apio (Research Assistant)

## 3.5 Changes in perceptions around pre and postnatal care

In this subsection, the evaluation focuses on answering the question: **To what extent have perceptions around pre and postnatal care changed in the target communities, and how successful were implemented strategies (which included engaging men and older women)?** The programme activities across the three locations aimed to influence practices and perceptions around attendance of ANC sessions; giving birth assisted by a skilled birth attendant; and babies receiving PNC from a skilled provider within two days of birth.

### Changes in prenatal perceptions and practices

Data from interviews with health workers and programme beneficiaries show women in the programme areas have changed their perceptions about prenatal care. Unlike before, they were now practicing better spacing of their pregnancies to avoid complications. Women across the three



locations were also putting emphasis on better nutrition during pregnancy, and promptly reporting any likely danger to the unborn baby to skilled medical professionals. They also mentioned early preparation as a common practice among the pregnant mothers; observed cleanliness and personal hygiene; ensured they were sleeping under mosquito nets to prevent malaria; and above all, they attended the recommended ANC visits.

A review of the HMIS data for 2020 from WCF and CUAMM for Oyam and Goro, and end-line evaluation for Luuka programme respectively, indicate that there were improvements in attendance percentages amongst mothers of children aged 0-11 months attending 4 or more ANC sessions with a skilled provider during their most recent pregnancy, from across the three programme locations. The improvement in ANC attendance attributable to the programme were higher in Oyam at 43%, followed Goro at 26% and lowest in Luuka at 8%.

Changes in perceptions around birth

Regarding practices and perceptions around skilled birth attended deliveries, data from interviews with women and men indicate that many expectant mothers across all programme locations were giving birth in health facilities. They were no longer using TBAs to assist them in deliveries. Many indicated that they go to the health centre at the first signs of impending labour, or they call for the ambulance to take them to the health centre. Programme reports from the three targeted locations indicate an increase in facility-based deliveries (SBA) from 45% to 58% for Goro,<sup>111</sup> and from 94% to 113% for Oyam.<sup>112</sup> In Luuka, SBA deliveries has increased from 73% at baseline to 91%.<sup>113</sup> The improvement in SBA deliveries across the three programme locations are almost similar in the Uganda programme locations and higher than in Goro.

Changes in perceptions and postnatal practices

Data from interviews with beneficiaries across the programme locations show that women had adopted the recommended postnatal practices, which include delaying bathing their babies after birth, keeping their babies warm, letting their babies get vaccinations, sleeping under mosquito nets and attending postnatal care visits 6 days after delivery. They also mentioned early initiation of feeding, as well as exclusive breastfeeding. Unlike before the intervention, they also mentioned good nutrition for the mothers as an important practice.

Programme reports indicate that the percentage of mothers of children 0-11 months receiving PNC within 2 days from a skilled provider had increased from 46% to 61.5% for Luuka,<sup>114</sup> while for Goro it had regressed from 7.1% to 4%.<sup>115</sup> Data on this indicator was not collected for Oyam. That said, there is an overlap of the SBA and PNC data since many mothers that deliver in a health facility spend a day or two in the centre before discharge, allowing them to receive the first PNC before discharge. Data from interviews with health workers and beneficiaries suggests that once discharged from the facility, unless the mother or baby experiences any sign of extraordinary discomfort, they rarely return for further PNC follow-up. In addition, PNC is also influenced by social norms that prohibit women from leaving their homes in the 2 months following delivery among the Oromos,<sup>116</sup> and for at least a week among the Luo (Oyam).<sup>117</sup> Among the Basoga, a woman is supposed to remain secluded until the cord falls off.<sup>118</sup>

Specific to Goro, most of the women interviewed mentioned that they no longer followed older practices, such as feeding butter to a new-born and applying cow dung to the new-born baby's cord. They also mentioned that they no longer allowed their baby girls to be circumcised, which was common practice before.

111 CUAMM. 2020. HMIS data analysis November 2020  
 112 WCF. 2020. HMIS data analysis November 2020  
 113 MakSPH. 2020. End-line evaluation report  
 114 Ibid  
 115 CUAMM. 2020. HMIS data analysis November 2020  
 116 CUAMM. 2019. Year 2 report  
 117 Interview with a female elderly participant, Oyam, Uganda  
 118 <https://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/1471-2393-8-21>



Table 8: Changes in perceptions around pre and postnatal care

<b>To what extent have perceptions around pre and postnatal care changed in the programme target communities?</b>			
Response	Goro	Oyam	Luuka
Greatly changed	94.7%	90.3%	93.8%
Moderately changed	0.0%	9.7%	6.3%
Don't know	5.3%	0.0%	0.0%
<b>Total</b>	<b>100.0%</b>	<b>100.0%</b>	<b>100.0%</b>

Overall, the perceptions around pre and postnatal care changed in the target communities in Goro, Oyam and Luuka. Asked about the extent to which perceptions around pre and postnatal care changed in these communities, 90% to 95% of the frontline health workers believe that perceptions have greatly changed. There is no significant difference between the programme locations. (See Table 8 above).

How successful were implemented strategies?

The programme has used a combination of approaches to sensitise communities and influence their perceptions and practices about pre, intra, and postnatal care. These include PLA sessions in Oyam and Goro; in Luuka, community sensitisation meetings used video shelters, and musical compositions by known celebrities. In both cases, a lot of visual elements were employed to illustrate or dramatise the message and facilitate understanding amongst the intended recipients.

Interviews with stakeholders and programme reports from Goro, Oyam and Luuka suggest that across all three locations the focus of the programme’s community sensitisation has been on deepening the community understanding of the benefits of reproductive, maternal, new- born and child health services, the risks of ignoring services such as ANC, and the importance of giving birth assisted by a skilled birth attendant, and attending PNC visits.

The changes in perceptions among the target communities in Goro and Oyam are attributed to the PLA approach. The importance of delivering at health centres assisted by a skilled birth attendant, of modern contraception and early breastfeeding was a central theme at the PLA meetings. The programme also used PLA sessions as a platform for awareness-raising conducted by professionals, invited from sub counties/kebeles and the district/woreda. In addition, VHTs, HDAs and HEWs trained by the programme continue raising awareness in the communities, as well as doing home visits to pregnant mothers to offer support and encourage care-seeking. In Luuka, the programme’s continued community sensitisation by health assistants and VHTs has focused on identification of danger signs, as well as on ANC, institutional delivery, cord care, KMC, PNC, and early breastfeeding. This is done through home-visits and video shows, and through community engagement following a maternal or neonatal death.

In Luuka, the community sensitisation took a different approach. Video recordings on matters of RMNCH were carefully screened and used. Video material was presented in the local community shelters, where women and men and youth would gather to watch musical video recordings of local celebrities. During or after the shows, the facilitators would have an interactive session on RMNCH, including pre and postnatal care practices. Interviews with communities suggest that they were attended by many women and youth, and less by men, as the latter perceived the programme and issues of RMNCH to be more for women than men.

Across the three programme areas, trained VHTs have been instrumental in the identification, follow-up and support of expectant mothers through information, referrals and emotional support. As respected members of the community, VHTs/HEWs and HDAs helped mothers in changing their attitudes towards RMNCH issues and in seeking services, such as ANC and PNC and FP services. Because of their proximity within the community, for instance, they accompanied mothers through



their pregnancy and until delivery. This helped in influencing perceptions around pre and postnatal care, and around RMNCH in general.

The programme in the three locations had a strong component for collaborating with and strengthening the health care system. Of specific interest were the provision of bespoke packages of essential equipment, drugs and supplies, and training of health workers, particularly midwives, in antenatal and neonatal care. This led to improvements in delivery of ANC and PNC services at the health centres, as well as to greater professionalism, improved care and attitude of health workers, all of which contributed to gaining the trust of women seeking these services.

In Oyam, Uganda, CHF funds have mainly been used to cover transport to HCs for mothers to access skilled birth attendants and to seek treatment for malaria, a malady that predominantly affects pregnant women and children. In Oyam, the programme has also sensitised TBAs to refer women to HCs for proper skilled care.

A comparison of the perceptions across the target areas in Oyam, Uganda, and Goro, Ethiopia, shows that the programme in Oyam has registered more improvements than in Goro, while a comparison of the three programme areas shows best performance in Luuka. Overall, therefore, the programme has had better effect on perceptions around RMNCH in Uganda than in Ethiopia.

There were no specific targeted strategies for increasing engagement with men and older women. PLA was expected to draw men and women of all ages to participate in the programme activities. Interviews revealed lesser numbers of men participating in the programme activities than women across all three locations. In Oyam, the element of VSLAs and CHF activities, in addition to generating resources and being available to members in the form of loans to cover their health care needs, also served to foster solidarity in the groups and cohesion among the members. The issues of pre and postnatal care were put on the agenda and discussed in the PLA groups and in CHF group meetings, and male members were encouraged to participate in ANC and PNC visits with their spouses. VHT members in a group interview suggested that “men and women were involved in maternal and child health issues in our community [more] than before”.<sup>119</sup> The men, unlike before the programme, were involved in early preparations for delivery, taking care of all eventualities, and hence preventing diseases and other complications that might arise during and after childbirth.

However, interviews with health workers also suggest that fewer men were accompanying their spouses for pre and postnatal care visits to the health centres mainly because of the transport cost. In Luuka, there was no strategy or intervention for promoting male engagement, and interviews with beneficiaries and health workers there generally suggest that the attitude of men towards RMNCH is negative.<sup>120</sup> However, in all three programme locations the men were reported to be readily obtaining what was needed to ensure their wives had safe deliveries, as well as items required for better maintenance of child health.

Family planning services greatly improved during the programme following adequate sensitisation and, most importantly, male involvement. Worth noting is that family planning uptake had been compromised by limited male involvement and often attracted violence and disagreement in families.

To conclude the assessment on the perception of pre and postnatal care, the analysis has revealed that perceptions around both have significantly changed in the target communities. There is an increased uptake of ANC and PNC services, and of RMNCH services generally. Although not as significant, there is also increased participation of men in ANC and PNC activities across all three locations although in varying proportions and intensity. For instance, there seems to be more male engagement in Oyam than in Goro and Luuka. However, even if men are not accompanying their spouses to ANC and PNC visits for various reasons (principally because of cost) they are willing to ensure that they provide for their spouses needs in regards to pre and postnatal care, deliveries, and other basic support, including proper nutrition for both mother and baby. The VHTs’ involvement and the health systems’ strengthening – including training of health staff, equipping health centres and supplying medical commodities across the three programme locations – and the VSLAs and CFU

<sup>119</sup> Group interview with VHTs, Otwal, Oyam, Uganda

<sup>120</sup> Interview with NGO worker, Luuka, Uganda

groups in Oyam have been identified as contributing to influencing perceptions around pre and postnatal care.

The assessment did not find deliberate interventions aimed at increasing older women's engagement. They are, however, involved in VHT work and, as former TBAs, they are more involved now in supporting referrals, care and counselling. They are also involved in PLA activities, like other members of the community.



### Lessons learnt

There is a close nexus between culture, traditions, religious beliefs and RMNCAH. Social norms still shape the perceptions of men and women and communities towards RMNCAH. These social norms influence hygiene, nutrition, FP, mobility of women to access services such as PNC. For instance, the Catholic Church forbids use of contraceptives,<sup>121</sup> while in some cultures that practice FGM there is a belief that FGM is recommended by Islam.<sup>122</sup> Yet FGM has a direct effect on MNCH. Cultural leaders, religious leaders, traditional leaders and clan leaders and elderly women, therefore, should have been targeted and involved in raising awareness, as they have far-reaching authority and influence in their community. Awareness-raising and community sensitisation, whether through PLA or use of videos, may increase knowledge about the importance of RMNCAH services and practices, but will not diminish generational social norms in the span of three short years. For example, there are a few practices -- such as ANC and SBA -- that have progressively changed because of the understanding of associated grave risks that can arise if these practices are not adhered to. However, the uptake of PNC is affected by social norms surrounding women's mobility post-delivery. This means that longer term programming is required to influence change in social norms. However, PLA has great potential to influence change in social norms, as it allows time during the sessions to interrogate the logic, benefits and risks, and informs group decisions.

#### Box 6: Change story 5: Improved health seeking behaviour

##### CHANGE STORY 5: Improved health seeking behaviour

*I am a female aged 34 from Otwal sub county, Oyam district. I am a peasant farmer. I joined the project as an ordinary member when CUAMM came to our village through the community health workers (village health teams). I participated in all the PLA activities, attending regular meetings and sensitization sessions. The group was so useful to me because I learnt a lot from the awareness sessions conducted. I learnt that it is important to always go to the health centre for better care whenever me and my children don't feel well. Most especially when I get pregnant it is important to attend **Antenatal Clinic (ANC) and prepare to deliver at the facility for a more skilled delivery.***

*When I joined the PLA group I learnt that malaria could be prevented by taking a monthly dose of fansidar and sleeping under treated mosquito net, a practice I embraced and the result was evident. I also convinced my husband to join and participate in the group activities. Most importantly we started **saving with the group for health emergencies. I also learnt the significance of involving a husband in the family health matters more especially the reproductive, maternal and child health issues.***

***When I got pregnant with my second child, I made sure I attend all the antenatal clinics and gave birth at the health centre. Even after being discharged, I made sure I go to the health centre with my baby for check-ups and immunisation. My husband has been accompanying me to the health centre. And I like it when he accompanies me with my child to the health centre.***

*We can now sit and discuss freely about family planning, child health and any other health concern in the family. My husband is more responsive and committed. We are all very healthy as a family.*

Compiled by Dinah Apio (Research Assistant)

<sup>121</sup> Interview with a female PLA facilitator, Ngai, Sub county, Oyam, Uganda

<sup>122</sup> Interview with a male participant, Dibdibe Abado, Goro, Ethiopia



### 3.6 Enabling and hindering factors

In this subsection, the evaluation focuses on answering the question: **What hindered or facilitated the implementation of national maternal and new-born health strategies in partnership with national governments, local health authorities and frontline health providers?**

#### **Facilitative factors**

The assessment identified the following factors as having facilitated the implementation of national maternal and new-born health strategies.

**Knowledge of the local context:** The implementing agency's familiarity with the local area was a great benefit. CUAMM has operated in Goro and Oyam, and generally in the Northern Region of Uganda, for a long time, through their "Mothers and children first", which aimed to improve and guarantee maternal and child health. The intervention under review was therefore a natural extension of the services already being offered. Moreover, CUAMM is trusted in the delivery of healthcare services, particularly specialised medical services in very hard to reach areas. CUAMM was well known and trusted by the communities as a partner. Their knowledge of Goro and Oyam, and particularly their services in St. Luke's Hospital in Wolisso, Goro, and Aber Hospital in Oyam facilitated the implementation of the interventions. Likewise, Makerere University School of Public Health was already known in Luuka because it is one of the districts where the school implemented model maternal and child health programmes before the COMONNETH project. It was already a trusted partner in the district.

**Availability of a well-organised health delivery system:** The programme in the three locations worked with an existing health structure that, in spite of some capacity gaps, was cooperative and willing to support the programme activities. The focus of the programme therefore was to strengthen the system.

**Attitudes and motivation of health workers:** Interviews with women beneficiaries indicated that one of the challenges they faced and/or that prevented them from using health facilities had been the negative attitudes and mistreatment/abuse by health workers, including slapping. The women, especially those from poor families, often felt humiliated by health workers. The change of attitude and practices of the health workers as a result of this programme therefore facilitated and attracted mothers to seek and use health facilities for ANC, skilled delivery and PNC.

**Responsiveness of local health authorities:** The programme in the three locations worked well with the local district authorities. In Oyam, district officials, especially the district health team and community development team, participated in some PLA sessions by invitation, where they received and responded to the issues raised by the participants, such as looking for resources to maintain the ambulance. In both Oyam and Luuka, the district responded to the needs for additional staff in the target health facilities due to the rising number of referrals and deliveries at the health centres.

**Community ownership of the programme:** Ownership of the programme by community structures is key to its success. Community structures such as the VHTs, HDAs, HEWs, PLA groups, and VLSA and CHF groups in Oyam were pivotal. This means RMNH issues were placed on the community agenda.

#### **Hindering factors**

The following were identified as hindering factors.

**Distance to the health facility:** One of the factors that hindered women from utilisation of MNH services was distance to the health facility. Data from interviews with women suggested that women from hard-to-reach areas -- hampered by broken down bridges, poor road networks and floods -- faced great difficulty in seeking ANC or PNC for non-emergencies. Even during emergency situations, it was sometimes difficult for ambulances to evacuate them when in labour. A poor transport system renders referrals impossible, leading to loss of life where emergencies cannot be effectively managed. The poor state of the community access roads further worsened the situation, especially in the rainy season.



**Cost factor:** Cost is one of the strong determinants in utilisation of health services in Uganda and Ethiopia. Interviews with women in Goro, Oyam and Luuka showed that the increase in uptake of ANC, health facility deliveries and PNC was because these services were free. However, the associated cost, especially for transportation to a health facility from remote areas, prohibited some women from accessing ANC and PNC services. It prevented men from accompanying their spouses to attend these visits, because they could not afford transport for two people, hence contributing to low male involvement. The lack of certain material things, like undergarments, also made women fear visiting the health facility for ANC.<sup>123</sup>

**Social norms:** As already mentioned in the previous section, there are many traditional beliefs and practices surrounding pre, intra, and postnatal care. These include nutrition of the expectant mother, use of traditional herbs, risky practices such as the management of the umbilical cord of the newborn, handling of births that may be twins, bathing babies immediately after birth because the baby is considered dirty, breastfeeding practices, confinement of a newly-delivered mother, etc. Other harmful practices include FGM in Goro. The community awareness-raising under the programme focused on addressing these social norms, but some of them still persist.

**Religious beliefs:** There is a close link between religion and RMNCAH practices, such as the use of contraceptives as a FP strategy. Some cultural practices, such as FGM, which is perceived as a recommended Islamic practice, also lead to complications that have implications for MNCH. However, interviews with various stakeholders revealed that the involvement of religious leaders in the programme across the three locations was conspicuously missing and, where one or two were involved, their involvement was not actively sought.<sup>124</sup>

**Cultural status of women:** Data from interviews with women and other stakeholders across the three programme locations showed that women have limited say in deciding issues, even those that affect their lives, including use of contraceptives, access to ANC or use of health facility for delivery, attending PNC or not, and when. For example, if the man is absent, this may prevent women from seeking timely access to health care.<sup>125</sup>

**Occupation of the women:** Data shows that the uptake of some MNH strategies was determined by the occupation of the woman. For example, career women found it challenging to practice exclusive breastfeeding or KMC in cases of premature births.

**COVID-19:** The onset of the pandemic, the implementation of the programme interventions and utilisation of health facilities. The lock-down measures prevented the PLA groups in Goro from completing the sessions, and affected other interventions, such as community sensitisation meetings in *Bibandas* in Luuka, access to health facilities for ANC and PNC services, follow-up and monitoring of programme activities, as well as support supervision.

### Other limitations

**Limited funding and resource allocation to the health sector:** Ideally, in both Uganda and Ethiopia, the national governments should have been allocating at least 15% of the national budget to the health sector, per the Abuja Declaration. Unfortunately, the health sector budget has stagnated between 8% and 9% in the past 15 years. At the district level, local revenue generation never caters to health funding needs, hence leading to poor implementation and low health outcomes. As a result, government health facilities suffer from inadequate supplies of essential medicines and equipment; this has been a major complaint from many health facilities in the district, as in other parts of the country. Coupled with this is the delay in deliveries by the National Medical Store (NMS), which supplies all the government facilities. Moreover, the "Push System"<sup>126</sup> does not favour Health Centre II and III levels, which continue to suffer from insufficient supplies and this, in

123 Interview with VHT, Otwal, Oyam district, Uganda

124 Interview with a district official Oyam, Uganda.

125 Interview with a district health team, Oyam; Interview with a medical doctor in Luuka.

126 The "Push System" refers to the supply of drugs and other medical consumables by NMS. NMS delivers every two months a Basic Kit (supply of drugs) to HC IIs and IIIs following a scheduled and published delivery schedule. The deliveries from the District level to the Health Centres II and III is done through private contracted transporters. The Basic Kit contains the basic Medicines that are supplied to all health centres II's and III's across the country. The Kit is revised every year to make it relevant to the local situation as per delivery schedule.



turn, affects their operations.<sup>127</sup> It is not uncommon to find a health centre running without gloves, and simple drugs for treating malaria, coughs, etc.

**Poor remuneration of health workers:** The health workers work very hard but are poorly remunerated. They are therefore not motivated to work at times, and this is often misinterpreted as negative attitude. The health workers sometimes exhibit rude behaviour towards the mothers. As a result, the latter fear coming to the health facilities for services, thus reducing uptake of maternal and child health services.

**Population pressure:** The quality and effectiveness of the RMNH services depends on the demand. Oyam district has a population of about 450,000 to 500,000. This implies that most of the facilities handle larger volumes of patients than is recommended<sup>128</sup>. Besides, there are not so many targeted interventions in the district. CUAMM happens to be the most popular agency offering maternal and child health support in the district. With such a strain on a single agency, there can't be effective implementation of the national and local level policies on maternal health. This is aggravated by the influx of patients from other districts for the limited services offered by CUAMM, as revealed in a key informant interview. In Goro, the CUAMM-run hospital is the only one in the woreda providing RMNCH services within a very big catchment area. In Luuka, the entire district did not have a single Health Centre IV offering a full range of services including EmOC. Facilitating the functioning of the theatre was timely, but its continued function requires a doctor and anaesthetist.

Overall, the success of this programme can be attributed to funded partners' knowledge of the local context, especially CUAMM and MakSPH -- which have operated in Goro and Oyam; and Luuka, respectively -- for a long time. The programme success is also attributed to having worked within an existing government healthcare system that offers free healthcare services in the three locations. The focus on systems' strengthening led to a more responsive service delivery, which in turn led to increased care-seeking practice among the target communities. However, household poverty, social norms, and other socioeconomic factors, such as the status of women in society and occupation/careers, and the COVID-19 pandemic, have had a negative influence on the outcomes of the intervention across the three locations.



### Lessons learnt

- The major lesson learnt is that, although poverty remains a hindering factor for access to RMNCAH services, through a combination of PLA and VSLAs and CHF, communities can become self-sufficient and more dynamic in finding their own solutions, rather than lamenting the lack of external help.

<sup>127</sup> Interview with a Health worker, Oyam, Uganda  
<sup>128</sup> Interview with DCDO



## 4. CONCLUSIONS

### *Impact on infant mortality and stillbirths*

Anecdotal evidence suggests that across the three programmes' locations there has been significant reduction in infant mortality and stillbirths in the target communities. This can be attributed to the mass awareness-raising and sensitisation conducted in the target communities by the trained community health workers/health extension workers, and village health teams/ health development army. In Oyam and Goro, the impact has been attributed to the awareness-raising on RMNCH issues in their communities by the programme which has led to increased uptake of pre and postnatal care services and improved health-seeking behaviour. The programme support to the three target districts has ensured that health centres are able to provide effective RMNCH services at all times.

However, the issue that remains unclear is whether the services at the health centres will maintain the same levels, and whether changed attitudes and practices in terms of health-seeking behaviours will be sustained. Some benefits and practices might persist -- such as deliveries in the health centres under skilled birth attendants, antenatal care, and child immunisations, because these are a government priority. However, some services may suffer because of stock-outs of drugs and other medical supplies. This is inevitable, but the PLA groups have acquired lobbying skills and they can continue to engage with government, district and sub county entities, pressuring them to ensure that the medicine stock-outs are minimised.

### *Successful strategies*

The most successful strategies in the implementation of pre and postnatal care practices include early identification and prevention of diseases such as malaria, HIV, STIs, diarrhoea and other preventable diseases; vaccination of mothers and babies; good nutrition, and emphasis on ANC by expectant mothers. Other strategies include provision of mama kits to expectant mothers, exclusive breastfeeding, delayed bathing of new-borns for 24 hours, and skin-to-skin contact. Another successful measure, exclusive to Oyam, is the promotion of solidarity groups (CHF and VSLAs) to save money to facilitate access to pre and postnatal care services.

### *PLA methodology*

The PLA methodology has proven to be an effective method for mobilising communities to participate in the programme in Oyam and Goro (although with disproportionate challenges). It is an empowering process even though it requires a heavy investment of time. For PLA to focus on the RMNCH agenda, facilitation handbooks were prepared with the necessary content. The process of organising and participating was largely influenced by the different socioeconomic and geographical factors. The assessment seems to suggest that the PLA sessions' facilitation and discussion were deeper and more engaging in Goro than in Oyam groups. In both locations, the main challenges to conducting/participating in the meetings were absenteeism and tardiness due to various reasons, but were more pronounced in Goro than in Oyam. The most difficult stages to implement were mainly the mobilisation stage (for both Oyam and Goro) and stages 8 and 9, which required community contribution. The assessment has revealed that in Ethiopia six groups did not complete all 14 sessions. This may require auditing in order to know the stages at which they stopped, so that they are assisted in completing the process.

In Oyam, the majority of the PLA groups have adopted other activities into their agenda, including VSLA and CHF, as prioritised solutions to the identified MNCH problems. The PLA sessions in both Oyam and Goro also provided space for the communities to interact with sub county/kebele and district/woreda planners to discuss the development needs as well as the suggested solutions by the communities. Building on this interaction, the implementing agency should have developed periodic policy briefs to share with the district leadership and the relevant actors at the national level, so as to inform district planning, national MNCH policy and practice.

### *Referrals and District management systems*

The assessment has revealed that there has been an increase in referrals across the three programme locations. This increase can be attributed to the programme's support for health



systems' strengthening in all three locations, as well as the programme's strategy of working with VHT/community health workers, continuous community awareness-raising and sensitisation, and the ambulance systems.

The increase in referrals and the resultant demand for MNCH services has exerted pressure on districts to plan and respond to the pressure by posting more staff to the health centres, improving coordination and reporting mechanisms, and carrying out regular support supervision. In Oyam district a few Health Centre IIs have been upgraded to Health Centre III level and equipped to provide pre and postnatal care.

### *Changes in perceptions*

The analysis has revealed that perceptions around pre and postnatal care have significantly changed in the target communities, in various proportions, the highest in Luuka, followed by Oyam and least in Goro. There is an increased uptake of general RMNCH services, particularly ANC and deliveries in health facility under skilled birth attendants. There is a gradual increase in the uptake of FP services. There is also a slow but steady increase in male engagement in Oyam, more so than in Goro and Luuka, with men accompanying their spouses for ANC and PNC visits.

The assessment did not find deliberate efforts to increase older women's engagement. However, a few older women were involved in VHT work, and as HDAs, and some former TBAs were supporting referrals, care and counselling. The youth were not adequately targeted. The targeting and involvement of religious leaders in the programme interventions, particularly PLA sessions, awareness and sensitisation, was also found to be conspicuously missing.

### *Enabling and hindering factors*

The analysis found that factors that facilitated the successful implementation of the national maternal and new-born strategies include knowledge of the local context by the implementing agencies and availability of a well-organised health delivery system. Other facilitative factors are the changed attitudes and motivation of health workers, responsiveness of local health authorities, and community ownership of the programme.

The assessment also identified factors that hindered the successful implementation of the national maternal and new-born strategies to include distance to the health facility; social norms including religious beliefs and cultural status of women, and environmental factors such as heavy rains and floods that make accessibility to services difficult. Other hindering factors are high costs involved in accessing MNH services. The team also identified other hindering factors such as limited resources allocated to the health sector, poor remuneration of health workers, and large populations that mount pressure on the few existing health services with limited staff. The COVID-19 pandemic has also hindered the successful implementation of the national maternal and new-born strategies.

## 5. RECOMMENDATIONS

### 5.1 Recommendations for the Comic Relief and Community Fund

1. This assessment has relied only on anecdotal evidence to conclude that the interventions have generated the desired impact, particularly in the reduction of infant mortality and stillbirths. While this may not be disputed, since the respondents know their communities, it still needs to be backed by statistical evidence. The district health departments and planning departments need to track maternal and neonatal and infant mortality rates to inform planning for an effective MNCH response. Currently there are gaps in the periodic monitoring data received from health centres and VHTs/HEWs. Future phases of the programme should support the development of such a tracking system, starting with the current target districts and eventually rolling it out to other districts and/or integrating it into the DHIS 2.
2. There is need for continued funding for the interventions in the target districts, possibly for another three-year phase, in order to continue with the community sensitisation and thus effectively foster positive change in MNCH practices. The focus should, however, have a wider scope so as to incorporate reproductive, maternal, neonatal, child and adolescent health



(RMNCAH) issues. During this extension, the PLA groups in Goro that did not complete their learning sessions can be facilitated to complete them. And additional strategies can be devised for increased participation of men, older women and youth, as well as inclusion of religious leaders as agents of change.

### 5.2 Recommendations for funded partners

3. The sustainability of PLA groups depends on the versatility to engage and tackle issues that affect them. Although the programme-sponsored PLA groups were focused on RMNCH issues, the assessment has shown that the Oyam PLA groups that have expanded their scope of prioritised solutions to include VSLA and CHF activities are more resilient and have more sustainability prospects than their counterparts in Goro. It is therefore recommended that, in future, the PLA facilitation handbooks should be revised to accommodate issues like saving and credit to improve household livelihoods and community health financing, since these complement each other in ensuring sustainable health outcomes.
4. There are increased referrals as a result of the programme interventions in the three locations, which have leveraged the healthcare service facilities to be effective. This support has proven that the healthcare systems can work but the government needs to invest in more resources to sustain them. Future programs should include lobbying and advocacy for increased government funding to improve MNCH service delivery.
5. Although the assessment has shown positive changes in perceptions around pre and postnatal practices, there are still constraining factors that affect the uptake of FP services and male engagement. These include economic factors – lack of money to afford costs, for instance, to accompany wives to ANC clinics – and prevailing social norms surrounding issues such as the mobility of new mothers seeking PNC services, or male participation in RNMCAH services, particularly FP services. Greater and sustained investment in awareness-raising and sensitisation of communities is needed to change generational social norms.
6. In future programmes, there is need to design specific strategies for effective engagement with different population groups, such as men, older women, and youth, as well as religious leaders.



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## Annex 1 – Terms of Reference

### Maternal and New-born Child Health

#### Executive Summary

Comic Relief is seeking a consultant/team of consultants to undertake the final evaluation of the neo-natal and maternal health programme co-funded by the National Lottery Community Trust and Comic Relief. All funded projects included a strong element of peer-to-peer support, using low-cost tools to effectively activate communities to take collective action to address health problems with locally designed solutions that are sustainable. The consultant(s) will conduct a review of the three projects funded in Uganda and Ethiopia, analysing secondary data and undertake remote key informant interviews, to understand what impact the projects had on pre- and post-partum care (both at home and in health facilities), what lessons can be learned from the organisations' participatory approach, and whether they are replicable in other similar contexts. We welcome in particular applications from teams of consultants whose members are either based in each of the two countries, or who can bring first-hand knowledge of the Ethiopian and Ugandan contexts.

#### Introduction to the Programme

In March 2015, Comic Relief and the National Lottery Community Fund (formerly Big Lottery Fund) announced a £5.5m partnership, of which £1.6m was used to fund projects working to improve the health of mothers, babies and children and improve the lives of people living in rural areas and urban slums in Africa. Although the number of deaths for children under five years has halved since 1990, mortality rates for new-born babies have remained consistently high. Sadly, each year 2.6 million new-born babies worldwide still die in their first month of life and 1 in 3 of these deaths occur on the first day of life. New-born babies now comprise 44% of under-5 deaths and as child mortality continues to decline, this proportion is set to increase. Shockingly, almost 3 million babies are stillborn every year, but these deaths are not even counted in the global burden of disease. Funding for neonatal health remains very limited and funding for stillbirths is negligible. There is still a woeful acceptance of stillbirths and new-born deaths as inevitable in many cultures and the grief of those affected by such deaths – women, parents, families and communities – is hardly ever heard by policy makers or politicians. The fact is that most babies' lives could be saved through proven, cost-effective interventions. With global agreement on a shared sustainable development agenda to 2030, based on the premise of 'leaving no one behind', now is the time to put neonatal survival on the agenda.

We strongly believe in supporting people-centred health systems to help individuals, families and communities overcome physical, financial and social barriers to good quality health care. To this end, the programme focused on the delivery of people-centred, primarily community-based, maternal, perinatal and neonatal health packages.<sup>129</sup> The aim of the initiative was to support some of the most vulnerable and hard-to-reach women, their babies and their families to access quality maternal and new-born care at the household and community level while strengthening their links with local primary health care providers and structures; in the long run, the ambition was to complement national health programmes, while strengthening health systems more broadly.

#### Projects funded

Three organisations received funding under this programme:

**Makerere University School of Public Health** – 'Community in which Mothers and New-borns Thrive', Luuka District, Uganda. Due to end: 1 October 2020. Expected outcomes: o Increased maternal and new-born health service utilisation;

- Improved screening for and management of mothers and new-born danger signs or are classified as high risk;

<sup>129</sup> Maternal health is defined as the health of the woman during pregnancy, childbirth and postpartum period. Perinatal health is the health of the unborn baby and new-born from 22 weeks into the pregnancy up to seven days after birth and includes stillbirth. Neonatal health is the health of the baby for the first 28 days after birth



- Improved knowledge of new-born care among women;
- Improved maternal and new-born birth outcome documentation at both community and health facilities;
- Improved partnerships with community-based organizations for maternal and new-born health.

**Doctors with Africa CUAMM:** 'Improving Maternal, Perinatal and New-born Health and Reducing Mortality in Goro Woreda, Ethiopia. Due to end: 30 September 2020. Expected outcomes: o Improved Reproductive, Maternal and New-born Health (RMNH) home-care practices in Goro Woreda;

- Improved RMNH care-seeking practices in Goro Woreda;
- To improve quality and accessibility of RMNH services in Goro Woreda;
- Improved attitudes, cultural norms and values in relation to RMNH in Goro Woreda.

**Women and Children First UK:** Improving Maternal, Perinatal and New-born Health and Reducing Mortality in Oyam District, Uganda. Due to end: 1 November 2020. Expected outcomes:

- Improved RMNH home-care practices in Myene and Ngai sub-counties of Oyam District;
- Improved RMNH care-seeking practices in Myene and Ngai sub-counties of Oyam District;
- To improve quality and accessibility of RMNH services in Myene and Ngai sub-counties of Oyam District
- Improved attitudes, cultural norms and values in relation to RMNH in Myene and Ngai sub-counties of Oyam District.

### Evaluation Purpose and Intended Audience

This evaluation intends to provide evidence as to what extent the organisations we supported were successful in empowering women, families and communities to actively improve maternal and neonatal survival through better education, positive behaviour change, improving MNH services and by implementing effective, yet low-tech, solutions. We see the role of community health workers, community midwives, other health volunteers such as up-skilled traditional birth attendants operating as 'birth companions', and community-based health structures such as women's groups or village health teams as essential to delivering these interventions and in order to link women and their families to good quality local maternal and neonatal health services. With this evaluation we intend to provide evidence not only on the 'what' works, but also on the 'how'; that is, what are the conditions that can foster effective and active engagement of communities in improving the health of mothers and babies, and influence health management at district level. Therefore, the intended audience of this piece of work includes all delivery partners and the two funders, community workers that led the delivery of the majority of the interventions, and the wider sector of actors in the maternal and neo-natal health space.

### Review Rationale and Learning Questions

The purpose of the evaluation is to summarize and analyze the outcomes of the Maternal New-born Child Health programme and what difference it made in the lives of the women and children who took part in it. All grants had a strong element of peer-to-peer support in their approach, such as Participatory Learning and Action (PLA) and Verbal and Social Autopsy (VASA) among others. We know that community mobilisation through PLA cycles with women's groups is recommended to improve maternal and new-borns' health, particularly in rural settings with low access to health services.

The organisations we funded focused on engaging communities through awareness raising, advocacy and social accountability in order to tackle stigma and discrimination associated with stillbirth and neonatal mortality, to improve the quality of maternal and new-born care offered and to help put stillbirths and new-born survival on the national agenda. The learning questions that we ask the consultant(s) to address are:

- a) What was the impact on infant mortality and stillbirths that the projects had, and what facilitated or hindered its implementation etc.);



- b) Which strategies were the most successful in the implementation of pre- and postnatal care practices and skilled delivery (including home care practices such as exclusive breastfeeding, skin-to-skin contact from birth, early onset of breastfeeding, ensuring babies are kept warm and ensuring basic prevention of infections) and why;
- c) Was there an increase in referrals to health facilities and improvement in skilled care during labour and birth, and how have these changes informed the district management systems;
- d) To what extent have perceptions around pre- and post-natal care changed in the target communities, and how successful were implemented strategies (which included engaging men and older women);
- e) What hindered or facilitated the implementation of national maternal and new-born strategies in partnership with national governments, local health authorities and frontline health providers.

### Approach and Methodology

In light of the current COVID-19 pandemic, we recognise that it will not be possible to make this review as participatory as we originally were planning to do. Therefore, we expect the consultant(s) to conduct mostly a desk-based review of the three projects that have been funded under this programme. Please note that only one of the partners (Makerere University School of Public Health) will conduct their own evaluation of their individual project, which will be made available to the consultant. For the other two projects, the consultant will base their review on the available annual, mid-term and final reports submitted by the projects, and any other secondary data that partners will be able to share. Both projects will also undertake an analysis of secondary data from the Health Management Information System (HMIS) on key MNH indicators, which will also be made available; the project in Ethiopia have also completed an EmOC facility readiness assessment. As currently it is not possible to interview the beneficiaries directly to add qualitative data (e.g. by conducting KII with CHWs or midwives as secondary sources) the consultant(s) will have to conduct interviews remotely with relevant key informants, health facility managers, key staff members etc.

Comic Relief's approach to learning is centred on our partners' needs and their understanding of the context in which they work. The design of MEL plans is underpinned by our principles of:

- collaboration and participation;
- be accessible and pragmatic, and;
- focused on learning that is actually used.

We expect the suggested methodology to be reflective of the current situation and ensure that none of our partners and their end users are put at any risk at any time, in particular considering their vulnerability. Therefore, we expect the consultant(s) to include a scoping stage in the evaluation plan, in order to validate with funded partners the feasibility of the approach in terms of capacity of staff, access to digital tools and ability to reach the target group. Although we expect most of the work to be desk-based (e.g. reviewing reports produced by funded partners, internal monitoring data and relevant case studies; conduct key informant interviews over the phone etc) we welcome applicants to suggest participatory approaches that they have tested before, that could be delivered safely in person or online (subject to acceptance from funded partners and social distancing rules enforced by local governments) with the intent of ensuring that both organisations and target group can actively contribute to the evaluation.

The lead consultant will need to ensure that the evaluation team is gender balanced ensuring that females are available to interact with female project participants and vice versa. The safety and well-being of everyone connected with our work is of paramount importance to us; therefore, the consultant will need to demonstrate how they have considered the protection of participants throughout the evaluation. This includes any recruitment and training of any research staff, data collection, analysis and report writing.

The consultant will also need to take into account principles of impartiality, respect for people, transparency, privacy, accountability and professional objectivity throughout the evaluation process.



### Evaluation/Learning product Management

Support will be provided by Comic Relief's Evaluation and Learning Manager and the Programme Manager, who will also facilitate the coordination with all partners. The consultant will be provided with a project information package of key documentation for review (grantee applications, annual and final reports and final evaluations; case studies). Both parties will be available for questions and discussions throughout the consultancy.

### Deliverables and Schedule

We expect this piece of work to be conducted between September and December 2020. The consultant is expected to produce the following deliverables:

- attend remotely an introductory meeting with Comic Relief (end of August ideally);
- develop a learning plan after consultation with funded partner (September);
- undertake an analysis of quantitative and qualitative data available (September-October);
- conduct interviews with funded partners and other key informants (September-November);
- facilitate any group learning sessions that might be required (Oct/Nov);
- produce 2 drafts of any written report for Comic Relief to provide feedback on (Nov);
- facilitate a findings session in CR with funded partners (Nov/Dec);
- produce a final report to include an executive summary, recommendations for funders and organisations involved (Dec);
- attend remotely a final debrief with Comic Relief (Dec).

### Budget

**Budget available: GBP 18,000** excluding VAT (if applicable) to cover all fees and expenses. Agreed expenses for travel and other costs can be claimed against receipts. Value for money will be considered when analysing the tenders.

### Applicant's Profile and Competencies

#### ESSENTIAL

- Sound and proven experience in conducting evaluations and assessments for international development programmes;
- Significant expertise in Monitoring, Evaluation and Learning;
- Ability to clearly communicate accessible findings and recommendations to a variety of audiences and stakeholders, i.e. without using jargon;
- A strong understanding of the context in which funded partners operate and previous experience of working in those countries and regions;
- Understanding of neo-natal and maternal health and experience in conducting evaluations of similar projects.

#### DESIRABLE

- Experience in facilitating learning and participatory processes to validate and integrate research findings into actions;
- Work in partnership with a team of consultants based in Ethiopia and Uganda;
- Experience in conducting phone-based/remote interviews;
- Experience in facilitating workshops and other learning activities online.

In line with our approach to fund those closer to the people directly affected by the issues, a greater weighting in scoring applications will be applied for those based within the country/region and who are led and driven by people from affected contexts. We believe that this will help to ensure we do not fall back into pre-conceived assumptions, and instead live our values of shifting power and amplifying local voices.



## Annex 2: Data Collection tools

### A 2.1: Interview schedule for Key informants

Telephone/Skype/Zoom

[Funded partners, Key Government Staff, NGO staff, and other informed stakeholders]

Name ----- Sex: M; F Date of Interview -----

Position/Title -----

Name of Organisation/Agency/Department

Name of District/Woreda -----

1. Please share a little bit about how you have been involved in this project?
2. How long have you been involved with the project?
3. In your opinion, what impact has this project had on infant mortality and stillbirths in your area?  
[long answer]
4. What facilitated or hindered its implementation and achievement of this change/impact?
5. What pre or post-natal care advice have you learned as part of the project? how often are you implementing them?
6. What project interventions would you say have been successful and why?
7. **[If you have taken part in the Participatory Learning and Action (PLA) sessions];** how effective was the PLA methodology in mobilising communities to take part in the project, learn, and stimulate action on RMNHC issues in their communities? How well were the PLA meetings conducted? What were the challenges in conducting/taking part in the meetings? Which stages of the PLA meetings were difficult to implement?
8. What changes have this project created in target communities around the area of reproductive, maternal neonatal and child health?
9. What unique strategies have been used by the project to create these changes?
10. What challenges could have hindered or facilitated the implementation of this project?
11. Now that the project has come (or is coming) to an end, what is likely to happen? What will stop and what will continue? Please explain your response.
12. Do kindly share with me anything else you would like us to know that you have not already in our conversation.

Thanks



### A 2.2: Survey for frontline workers and beneficiaries

To use Google forms or Survey Monkey and as a Key informant Interview for those that cannot use google forms

Health workers – Doctors, Clinical Officers, Midwives, Nurses, Health educators, Community Health Workers (CHWs – Ethiopia), Village Health Teams

Name ----- Sex: M; F Date of Interview -----

Position/Title [List: Doctor; Clinical Officer, Midwife, Nurse, Health Educator, VHT, CHW, Social Worker, Other]

Name of Facility/Organisation/Agency/Department

Name of District/Woreda -----Name of Sub county/Kebele -----

1. Please share a little about how you have been involved in this project?
2. How long have you been involved with the project?
3. What impact has this project had on infant mortality and stillbirths in your area? [long answer]
4. What strategies used in implementing this project do you recall, to have proven most successful in implementing pre- and postnatal care practices and skilled delivery, particularly?
5. Did you take part in the project PLA sessions – Yes/No [If no, skip to Qn.10]
6. How effective was the PLA methodology in mobilising communities to take part in the project, learn, and stimulate action on RMNHC issues in their communities? (If you did not skip
7. How well were the PLA meetings conducted?
8. What were the challenges in conducting/taking part in the meetings?
9. Which stages of the PLA meetings were difficult to implement?
10. Has there been an increase in referrals to health facilities? Please explain your answer
11. Has there been any improvement in skilled care during labour and birth? If so how have these changes informed the district health management systems? Please explain your answer
12. To what extent have perceptions around pre- and post-natal care changed in the project target communities?
13. What strategies have been used to influence these perceptions in 12 above?
14. Which of these implemented strategies aimed at influencing community perceptions were most successful? And why?
15. What barriers/challenges could have hindered or facilitated the implementation of national maternal and new-born strategies in partnership with national governments, local health authorities and frontline health providers in pursuit of the goals of this project in your district/area? [list]
16. Now that the project has come (or is coming) to an end, what is likely to happen? What will stop and what will continue? Please explain your response.
17. Kindly provide any other information here that you would like us to know that you have not already provided in your answers above?

Thanks



**A 2.3: Survey for end-user beneficiaries (women and men)**

*[Survey to be administered via Telephone Interviews – to be recorded and transcribed or directly using a mobile data device e.g Tab or Smart phone]*

Name ----- Sex: M; F Date of Interview -----

Name of District/Woreda

Name of Sub county/Kebele

Name of your village

Occupation

We are now going to ask you questions to assess how this project has impacted on you and your community.

1. Please share a little about how you got involved in this project
2. How has this project changed your community regarding issues of reproductive, maternal, neonatal and child health most especially infant mortality and stillbirths].....
3. Did you take part in the project PLA sessions – Yes/No [If no, skip to Qn.8]
4. If yes, how effective was the PLA methodology in mobilising communities to take part in the project, learn, and stimulate action on RMNHC issues in their communities?
5. How well were the PLA meetings conducted?
6. What were the challenges in conducting/taking part in the meetings?
7. Which stages of the PLA meetings were difficult to implement?
8. Do you find it easier to talk to health workers and receive support? Yes /No. Why
9. Do you breastfeed your babies? Yes/No. If no, explain .....
10. Have you tried skin-to-skin contact strategy with your babies? Yes/No. If No why?
11. Do you now visit the health centre more often to seek pre- and postnatal care services? Yes/No. Explain your answer
12. Since the project has been implemented, has the quality of services offered to women and children at your local health facility changed? Yes/No Explain .....
13. Since this project has been implemented, has the accessibility to reproductive, maternal, neonatal child health care services targeting women offered at your local health facility improved? Yes/No: Explain -----
14. Since this project has been implemented, have women changed any of their practices during pregnancy? Yes/No: Explain .....
15. Since this project has been implemented, have women changed any of their practices during and after childbirth? Yes/No Explain .....
16. Among the project activities, (e.g Engaging men and older women, Participatory Learning and Action sessions, Community sensitisation, Advocacy, and Training) what do you think has contributed most in influencing peoples’ perceptions on reproductive, maternal, neonatal child health? Explain your answers .....
17. In your opinion how have the community perceptions about reproductive, maternal, neonatal child health changed because of the project? Explain .....
18. Now that the project has come (or is coming) to an end, are you likely to continue visiting the health centre for pre- and postnatal care services? Yes/No. Explain your answer.
19. What have you learnt from the project that you are to continue using/applying to avoid pre-or postnatal challenges for yourself as woman (for your wife) and your child/ren?

Thank you for your participation



## A 2.4: Focus Group Discussion

*[To use Zoom and/or Phone call]*

1. What was the impact on infant mortality and stillbirths that the projects had, and what facilitated or hindered its implementation (e.g. change in attitudes, overcoming tangible barriers, self-efficacy of women, working closely with health workers, etc.);
2. Which strategies were the most successful in implementing pre- and postnatal care practices and skilled delivery (including home care practices such as exclusive breastfeeding, skin-to-skin contact from birth, early onset of breastfeeding, ensuring babies are kept warm and ensuring basic prevention of infections) and why;
3. Since the project has been implemented, has the quality of your local health facilities in the project catchment areas changed? How has it changed and why/how has it failed to change and why?" [Probe for quality of service: tangible, reliable, responsive, assurance and empathy of staff]
4. Since this project has been implemented, has the accessibility of the local health facilities changed? How have they changed and why?/how has it failed to change and why?" [Probe: approachability, acceptability, availability, affordability and appropriateness].
5. Since this project has been implemented, have women changed any of their practices during pregnancy? Which practices have they changed and why?/Why have they not changed their practices?" [Probe for: Nutrition; Prevention, testing and treatment for malaria].
6. Since this project has been implemented, have women changed any of their practices during and after childbirth? Which practices have they changed and why?/Why have they not changed their practices?" [Probe for: Infection prevention; Thermal care; Breastfeeding].
7. Was there an increase in referrals to health facilities and improvement in skilled care during labour and birth, and how have these changes informed the district management systems;
8. To what extent have perceptions around pre- and post-natal care changed in the target communities, and how successful were implemented strategies (which included engaging men and older women);
9. What hindered or facilitated the implementation of national maternal and new-born strategies in partnership with national governments, local health authorities and frontline health providers.
10. Now that the project has come (or is coming) to an end, what is likely to happen? What will stop and what will continue? Please explain your response?

Thank you all for your participation.



### Annex 3 Outline of the PLA phases and meetings and the content covered

The PLA programmes in Oyam and Goro had slightly different cycles but the outline below covers the overall content and phases of both programmes.

Phase	Meetings and content covered
<p><b>Phase 1: Identify problems</b></p>	<ul style="list-style-type: none"> <li>⌚ <b>Meeting 1:</b> The initial meeting is preliminary and called to introduce members to the project and the need to form a learning group and to explain that attendance will not be remunerated and not even providing drinks. The members agree on the meeting day, time and the rationale.</li> <li>⌚ This meeting also involves group formation, in which the facilitator introduces the PLA-MNH group approach, explains the principles of the PLA-MNH group approach and the group establishes a committee and ground rules.</li> <li>⌚ <b>Meeting 2:</b> In this session the group identifies new-born health problems. The members learn about health problems affecting new-borns during childbirth and up to one month after birth. The group also prioritises the most important new-born health problems in the community.</li> <li>⌚ <b>Meeting 3:</b> The group identifies and learns about health problems affecting women before pregnancy, during pregnancy, during childbirth and up to one month after birth. During the session, the group also prioritises the most important maternal health problems in the community.</li> <li>⌚ <b>Meeting 4 (Specific to Oyam),</b> The meeting is on Adolescent Health. During the session the group learns about health problems affecting adolescents before and during pregnancy, child birth, immediately after birth and the longer term. The meeting also prioritises the most important adolescent health problems in the community.</li> </ul>
<p><b>Phase 2: Identify solutions</b></p>	<ul style="list-style-type: none"> <li>⌚ <b>Meeting 5:</b> In this meeting the group identifies prevention and management behaviours. The group learns about the behaviours that can help to <b>prevent</b> maternal and new-born health problems from arising. It also learns about the behaviours that can help to <b>manage</b> maternal and new-born health problems if they have already arisen. The session is also used by members to identify the behaviours that can help to prevent and manage the priority maternal and new-born health problems in the community.</li> <li>⌚ <b>Meeting 6:</b> During this meeting, the group members identify solutions. The members learn about the barriers that people can face in performing prevention and management behaviours; identify the barriers that people can face in performing prevention and management behaviours for the priority maternal and new-born health problems in the community; and identify the solutions to these barriers.</li> <li>⌚ <b>Preparation for meeting 7:</b> The group meets to prepare and practice for the presentation to the community in the next meeting.</li> <li>⌚ <b>Meeting 7:</b> The Community members are invited and the PLA group presents progress of the group from meetings 1-6, gather the ideas and opinions of the whole community seek support from the whole community to implement the group solutions.</li> </ul>
<p><b>Phase 3: Implement solutions</b></p>	<ul style="list-style-type: none"> <li>⌚ <b>Meeting 8:</b> The group develops an action plan for group solutions</li> <li>⌚ <b>Meeting 9:</b> The group plans how to mobilise any resources, needed to implement the group solutions, and proceeds to implement and monitor their group solutions for approximately three months.</li> </ul>



<b>Phase 4: Evaluate solutions</b>	<ul style="list-style-type: none"><li>④ <b>Meeting 10:</b> The group meets to evaluate the impact of the solutions and to plan how to strengthen the solutions.</li><li>④ <b>Meeting 11:</b> Plan for the future. The group in this meeting planning what it should do next as well as planning for how to strengthen the group.</li><li>④ <b>Preparation for Meeting 12:</b> The group meets to prepare and practice for the presentation to the community in the next meeting.</li><li>④ <b>Meeting 12: Community meeting 2</b> for the group to present progress of the group from meetings 8-12 as well as to gather the ideas and opinions of the whole community to get support from the whole community for the future</li></ul>
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## Annex 4: Uganda Healthcare System

**(Health Centre I - Village health teams (VHTs))** constitute the first level of the healthcare service provision in Uganda. These are usually 2 volunteers selected from within and operate in each village (Local Council 1, or a cell). The role of VHTs is carrying out health education at household and community levels; conducting house-to-house visits for health improvement; participating in integrated community case management of childhood illnesses of pneumonia, malaria and diarrhoea; referral of patients to health facilities; as well as mobilisation of communities for public health interventions such as immunisation of children and distribution of mosquito nets.

**Health centre II** is the next level in the healthcare delivery system. According to the Government of Uganda health policy, every parish is supposed to have one of these centres. A health centre II facility, serves at least 5000 people, is equipped to treat common diseases like malaria and 2 beds for emergency deliveries. It has 9 staff. HC II offers preventive, promotive, outpatient, curative health services and emergency delivery. **Health centre III** is a facility found in every sub-county in Uganda. It has a catchment area of 20,000 people. The Health Centre III is designed to have 14 beds, and should have about 19 staff, led by a senior clinical officer. It should also have a functioning laboratory. The health centre offers preventive, promotive, outpatient, curative, **maternity**, inpatient, laboratory services.

**Health centre IV/District Hospital** This level of health facility serves a county, but with the continuing creation of smaller district administrative units in Uganda, Health Centre IV is now the *de facto* district hospital many districts of Uganda. It has a catchment area of 100,000 people. It is designed to have 24 beds and 50 staff. HC IV offers preventive, promotive, outpatient, curative, **maternity**, inpatient, laboratory, ultrasound examinations (**for obstetric cases**), **emergency /simple surgery (including caesarean sections and life-saving surgical operations)**, **blood transfusion services** and mortuary.

**General Hospital:** The District Hospital serves a district and is designed to serve a catchment area of 500,000 people. It has capacity of 100-250 beds and 185 staff. In addition to the services offered at the Community Hospital provides services for general medical and surgical conditions, specialist services in Medicine, Surgery, Paediatrics, Community Medicine; and Obstetrics & Gynaecology. It also provides in-service training and basic research.

**Regional Referral Hospital (RRH)** There are 10 RRH in the country. The Regional Referral Hospital serves a region and is designed to serve a catchment area of 2,000,000 people. It has capacity of 500 beds and 349 staff. In addition to services provided at the General Hospital, specialist services are provided including; psychiatry, ear, nose and throat, ophthalmology, dentistry, intensive care, radiology, pathology, higher level surgical and medical services. It also provides in-service and pre-service training and internship.

**National Referral** on the top of the healthcare chain is the national referral hospitals. The National Referral Hospitals are designed to serve a population of up to 10 million people. It should have capacity of 600 and more beds and 1500 staff. In addition to services provided at the RRHs, provides Super specialist services e.g. Nephrology, Neurology, Endocrinology and Metabolic diseases, Gastroenterology, Respiratory Medicine, Neonatal care, Intensive care, Nuclear medicines, Neurosurgery and Cardiothoracic surgery. Diagnostic services e.g. MRI and CT Scan, Advanced clinical laboratory services in Microbiology, Haematology, etc. In addition, provides postgraduate and under graduate training, internship and advanced research.



## Annex 5: Ethiopia Healthcare system

HSDP IV has introduced a three-tier health-delivery service system. The primary level consists of primary healthcare units (health posts and health centres) and primary hospitals; secondary level services are provided by general hospitals; and tertiary services by specialized hospitals.

### **Primary level**

At the lowest rung in the primary level is a **health post**, which is meant to service a catchment area with a population of 3000 – 5000 people. Health posts are staffed and managed by health extension workers. Next is the **Health Centre** which serves a catchment area with a population of 15,000-25,000 people. The urban health centres are designed to serve a population of about 40,000 people. The health centre is serviced by conventional medical staff, including doctors, midwives and nurses. The highest in the primary level is the Primary Hospital, which serves a population of 60,000 -100,000 people. All the primary level health facilities are financed and managed by the Woreda-level health authority, that is, Woreda Health Office (WorHO).

### **Secondary level**

At the secondary level, the General Hospital services 1,000,000 – 1,500,000 people. The General Hospitals operate at a regional level and are financed and managed by the regional-level health authority – Regional Health Bureaus (RHBs).

### **Tertiary level**

At the tertiary level, there are Specialised Hospitals meant to serve a population of 3,500,000 to 5,000,000. Specialised Hospitals are financed and managed by the federal-level health authority, that is, Federal Ministry of Health (FMOH).

In addition to the health service delivery system highlighted above, Ethiopia has an elaborate **Health Extension Program (HEP)**, which is one of the strategies for achieving universal coverage of primary health care among the rural population by 2009, in a context of limited resources. The overall goal of HEP is to create a healthy society and reduce maternal and child morbidity and mortality rates. The HEP program is deeply rooted in communities, providing primary level preventive activities to household members. The program encourages families to be responsible for their own health by promoting knowledge dissemination and adoption of hygiene practice and feeding practice, and appropriate health-seeking behaviour from professionals and proper community management. This community outreach ensures a sense of ownership and creates sustainable changes in communities.

## Annex 6: List of Respondents

List of community interviews

Name	Sex	Name of District/Woreda	Name of Sub county/Kebele	Name of your village	Occupation
Aster Neguse	Female	Goro	Denbeli Dilela	Abu	Farmer
Zeyneba Jemal	Female	Goro	Dibdibe Abado	Kawo	Farmer
Diriba Nuresa	Male	Goro	Fugo Oda Mela	Shema	Farmer
Ketela Wakgari	Male	Goro	Dibdibe Abado	Kekeki	Farmer
Neima Jemal	Female	Goro	Dibdibe Abado	Dibdibe Abado	Farmer
Adanu Abebe	Female	Goro	Denbeli Dildila	Chebo Alga	Farmer
Mitike Garumsa	Female	Goro	Denbeli Dilela	Lemen	Small business
Jemila Nurisa	Female	Goro	Fugo Oda Mela	Shema	Farmer
Nedi Negesu	Female	Goro	Dibdibe Abado	KomO	Farmer
Batri Abule	Female	Goro	Oda Fugo Mela	Iftu	Small Business
Ayelech Sirna	Female	Goro	Lemen Abo	Madera	House wife
Chaltu Kedir	Female	Goro	Finchir Ambebesa	Chiri	Farmer
Zebiba Sulutan	Female	Goro	Abado Bukasa	Bukasa	Farmer
Shume Sulutan	Female	Goro	Chireche Tadera	Gossa	Farmer
Mekiya Beyene	Female	Goro	lemen Abo	lemen	Farmer
Zeyneba Tolosa	Female	Goro	lemen Abo	Lemen	Farmer
Remla Husen	Female	Goro	GURURA	Abdi bori	Farmer
Mohammed Amin	Male	Goro	Lemen Abu	Lemen	Farmer
Buzu shiferaw	Female	Goro	Adami wedesa	Buruqe	Farmer
Kebebi Workineh	Female	Goro	Chirecha	Yerer	Farmer
Teyba Jemal	Female	Goro	Wayu	Baddiya	Farmer
Abaynesh Siyuem	Female	Goro		Gere Tokkofa	Farmer
Belaynesh Teka	Female	Goro	Gurura	Abdi boru	Small Business
Abebech Gebre	Female	Goro	Gurura	Biftu	Small Business
Zebiba Abdulwase	Female	Goro	Finchira Ambebesa	Bdatu	Farmer
Workitu Tolera	Female	Goro	Chirecha Tadra	Chirecha	Farmer
Fate mohammed	Female	Goro Town	Chebo	BERIO	Farmer
Nairuba Merabu	Female	Luuka	Bulongo	Bubonoka	peasant farmer
Namabi Mercy	Female	Luuka		Bulike	peasant farmer
Waiswa George	Male	Luuka	irongo	irongo	
Babirye Angella	Female	Luuka	irongo	irongo	VHT
Kataike Agnes	Female	Luuka	Bulongo	Bubonoka	Retail shop
Kakungulu Bakali	Male	Luuka	Bukanga	Busalamu	Small Cane Truck driver

Kaudha Edinansi	Female	Luuka	Butagaya	Nawampanda	peasant farmer
Mugaiga Nuulu	Female	Luuka	Bulongo	Kiyunga	peasant farmer
Obbo Martin	Male	Luuka	Bukooma	Naibika	Brick layer
Kabiru Paulo	Male	Luuka	Bukooma	Busanda	Peasant farmer
Nabirye Sharon	Female	Luuka	Ikumbya	Namabuga	seling farm produce
Brenda Ayubu	Female	Oyam	Ngai	Acut	Farmer
Saida Agwe	Female	Oyam	Ngai	Abil	Peasant farmer
Abonyo Caroline	Female	Oyam	Ngai	Abil	Farmer
Bosco Okello	Male	Oyam	Ngai	Bar-dyel	Farmer
Ekol Aeron	Male	Oyam	Abok	Illodo	Farmer
Evelyn Nyana	Female	Oyam	Ngai	Abil	Farmer
Susan Adong	Female	Oyam	Ngai	Acut	Farmer
Scovia Angom	Female	Oyam	Ngai	Acut B	Farmer
Janet Alupo	Female	Oyam	Myene	Abongi piny	Farmer
Okello Tom	Male	Oyam	Myene	Abongi piny	Peasant farmer
Lilly Olinga	Female	Oyam	Ngai	Abil	Farmer
Ayang Janet	Female	Oyam	Abok	Lela Acol	Business
Oceda Peter	Male	Oyam	Abok	Lela Acol	Farmer
Stella Abong	Female	Oyam	Abok	Ilodo	Business
Alex Otim	Female	Oyam	Abok	Ilodo	Farmer
Anyango Harriet	Female	Oyam	Otwal	Bar nyang	Farmer
Akello Margret	Female	Oyam	Otwal	Bar nyang	Business
Awili Grace	Female	Oyam	Otwal	Kot okello ayela	Farmer
Rose Adong	Female	Oyam	Otwal	Telela	Farmer
Nancy Acio	Female	Oyam	Otwal	Telela	Farmer
Scovia Atala	Female	Oyam	Otwal	Bar nyang	Farmer
Sara Awino	Female	Oyam	Otwal	Bar dam	Farmer
Nancy Awino	Female	Oyam	Otwal	Lela dyel	Farmer
Auma Judith	Female	Oyam	Otwal	Anyomolyec	Business
Dellis Apio	Female	Oyam	Otwal	Bar nyang	Farmer
Abongi Stella	Female	Oyam	Myene	Acawaratera	Farmer
Susan Otema	Female	Oyam	Myene	Acwaratera	Farmer
Tom Obua	Male	Oyam	Myene	Bar Dyel	Farmer
Akello Molly	Female	Oyam	Otwal	Kot okelo ayela	Farmer
Gloria Akite	Female	Oyam	Abok	Lela col	Farmer
Acen Janet	Female	Oyam	Abok	Lela col	Farmer
Innocent Ocan	Male	Oyam	Abok	Illodo	Farmer
Joan Angwech	Female	Oyam	Otwal	Ayamo kuta	Farmer
Acayo Florence	Female	Oyam	Ngai	Bar aciel	Farmer

Eunice Etap	Female	Oyam	Myene	Bar Dyel	Farmer
Beatrice Awidi	Female	Oyam	Myene	Barilaka	Farmer
Gabriel Ocien	Male	Oyam	Myene	Barilaka	Farmer
Akello Vicky	Female	Oyam	Myene	Abongi piny	Farmer
Michael Olinga	Male	Oyam	Ngai	Abil	Farmer
Apili Caroline	Female	Oyam	Ngai	Acut B	Farmer

**List of Frontline workers**

Name	Sex	Position	Organisation/Department/Agency	District/Woreda	Subcounty/Kebele
Geremu Refu	Male	Community Health worker	Government health center	Goro	Dambi Kono
Desale Hailu	Male	CDC Expert	Government	Goro	Kebele 01
Aster Tesfaye	Female	Community Health worker	Local Government (Kebele level)	Goro	Dembeldidila
Tsehay Kebede	Female	Community Health worker	Local Government (kebele level)	Goro	Chancho Soyoma
Alewuya Ahmedin	Female	Community Health worker	Kebele health center	Goro	Galeyi Rogda
Amina Yesuf	Female	Community Health worker	Local government - Kebele level	Goro	Finchirambabesa
Goro	Female	Community Health worker	Government health center	Goro	Fugo Oda Mela
Meselech Mekonnen	Female	Community Health worker	Government health center	Goro	Chirecha Tedra
Sadiya Oli	Female	Community Health worker	Government health center	Goro	Dogema Dambi
Alemnesh Likisa	Female	MCH Worker	Woreda/ District Health Center	Goro	Goro
Burtukan Tadele	Female	MCH Expert	Health Center (government)	Goro	Wayu
Getu Milkesa	Male	MCH Expert	Health center (government)	Goro	Wayu
Tamirat Adugna	Male	Health Extension Coordinator	Kebele (sub district) health center	Goro	Wayu
Tamirat Mechesa	Male	Head of Health Center	Gurura Health Center (government)	Goro	Gurura
Abera Abdisa	Male	Head of the local health center	Burka Bido Health Center (government)	Goro	Burka Bido
Abebe Genet	Male	Deputy head of the health center at sub district level	Gurura Health Center (Government)	Goro	Gurura
Fatiya Negesu	Female	MCH Expert	Gurura Health Center (government)	Goro	Gurura
Oliyad Abire	Male	Community Health worker	Gurura Health Center (government)	Goro	Goro
Esther Kampi	Female	Community Health worker	Luuka District - Health Department	Luuka	Bukanga Sub county
Rabecca	Female	Midwife	Luuka District - Department of Health Waibuga Health Centre	Luuka	Waibuga
Dr. Felix	Male	Doctor	MakSPH - Luuka Health Centre IV	Luuka	Luuka
Nabirye Joy	Female	Midwife	Luuka District Local GOVERNMENT	Luuka	Nawampiti
Damalie Inhensiko	Female	Midwife	Luuka District Local Government	LUUKA	Bukanga
Joyce Matama	Female	Midwife	Luuka District Local Government	Luuka	Bukanga
Janet Mudondo	Female	Midwife	District Health department	Luuka	Kiyunga
Cyrus Musisi	Male	Clinical Officer	District Health department	Luuka	Sirongo

Andrew Ssegonga	Male	Clinical Officer	District Health department	Luuka	Ikumbya
Nakamatte Monic	Female	Village Health Team member	Bukooma sub county	Luuka	Bukooma
Margaret	Female	Midwife	District Health department	Luuka	Ikumbya
Margaret Ndikeyimwiza	Female	Midwife	District Health department	Luuka	Kiyunga
Katende Beatrice	Female	Village Health Team member	Community volunteer	Luuka	Kumbya
Magoola Grace	Male	Village Health Team member	Luuka Town Council	Luuka	Luuka Town Council
Ngobi Grace	Male	Village Health Team member	Luuka District Local Government	Luuka	Nawampiti
Kisambaga Robert	Male	Village Health Team member	Luuka District Local Government	Luuka	Ikumbya
Opio Eunice	Female	Community Health worker	CUAMM	Oyam	Abok
Evelyn Akello	Female	Community Facilitator	CUAMM	Oyam	Myene
Tom Okello	Male	Village Health Team member	CUAMM, District Health Department	Oyam	Myene
Patrick Omara	Male	Village Health Team member	District Health department, CUAMM	Oyam	Abok
Harriet Adong	Female	Community Facilitator	District Health department, CUAMM	Oyam	Otwal
Denis Aryono	Male	Village Health Team member	District Health department, CUAMM	Oyam	Myene
Milton Ogwal	Male	Village Health Team member	District Health department, CUAMM	Oyam	Abok
Pamela Angom	Female	Community Health worker	District Health department, CUAMM	Oyam	Otwal
Bonny Moro	Male	Clinical Officer	District Health department	Oyam	Ngai
Tonny Ocen	Male	Clinical Officer	District Health department	Oyam	Abok
Richard Ogwal	Female	Clinical Officer	District Health department	Oyam	Otwal
Grace Angom	Female	Community Health worker	District Health department	Oyam	Myene
Beatrice Otak	Male	PLA Facilitator	CUAMM	Oyam	Myene
Jackline Adong	Female	Community Health worker	CUAMM	Oyam	Ngai
Night Odongo	Female	PLA facilitator	CUAMM, District health department	Oyam	Ngai
Florence Auma	Female	PLA Facilitator	CUAMM	Oyam	Otwal
Daniel Okwir	Male	Clinical Officer	District health department	Oyam	Otwal
Bonny Okwir	Male	Clinical Officer	District health department	Oyam	Otwal
Martin Ogwal	Male	Community Health worker	District health department	Oyam	Ngai
Martin Ogwal	Male	Community Health worker	District health department	Oyam	Ngai
Fred Oyugi	Male	Community Health worker	District health department, CUAMM	Oyam	Otwal
Moses Ogwang	Male	Community Health worker	District health department	Oyam	Myene
Isaac Ayo	Male	Village Health Team member	District health department, CUAMM	Oyam	Myene
Joyce Akello	Female	PLA Facilitator	CUAMM	Oyam	Ngai
Grace Amongi	Female	Community Health worker	District health department, CUAMM	Oyam	Ngai
Sandra Ejang	Female	Midwife	District Health department	Oyam	Abok
Simon Opok	Male	Village Health Team member	District Health department	Oyam	Myene
Hellen Brenda Ajok	Female	Community Health worker	CUAMM	Oyam	Otwal
Peter Aner	Male	Village Health Team member	District Health department	Oyam	Myene
Nancy Ocwet	Female	Community Health worker	CUAMM	Oyam	Myene
Miriam Ocien	Female	PLA Facilitator	CUAMM	Oyam	Ngai



## Annex 7 – Evaluation matrix

Learning Question	Our Understanding of the Question	Methods and Tools	Sources of Information
1. <b>What was the impact on infant mortality and stillbirths that the projects had, and what facilitated or hindered its implementation (e.g. change in attitudes, overcoming tangible barriers, self-efficacy of women, working closely with health workers, etc.)</b>	We shall rely on the individual project evaluations (midterm and end-term) to trace the recorded impact of the projects by each outcome indicator. Our role will largely be to validate this and then focus on the factors that have facilitated or hindered the implementation of the project to realise its expected impact ( <b>impact assessment</b> ).	<ul style="list-style-type: none"> <li>🕒 Document review</li> <li>🗣️ Key informant interviews</li> <li>👥 Focus group discussions</li> <li>🏠 MSC workshops</li> </ul>	<ul style="list-style-type: none"> <li>📄 Project documents (especially their theories of change/log frame matrices)</li> <li>📄 Baseline, midterm, and end-term evaluation reports</li> <li>👥 Project staff of implementing organisations</li> <li>👥 National- and district-level health officials</li> <li>👥 Hospital and health centre staff (midwives, nurses, and clinical officers)</li> <li>👥 Village health teams</li> <li>👥 Male and female community members</li> </ul>
2. <b>Which strategies were the most successful in the implementation of pre- and postnatal care practices and skilled delivery (including home care practices such as exclusive breastfeeding, skin-to-skin contact from birth, early onset of breastfeeding, ensuring babies are kept warm and ensuring basic prevention of infections) and why</b>	Our focus will be on assessing <u>which</u> strategies adopted in the three projects were most successful in implementing pre- and postnatal care practices and skilled delivery and <u>why</u> . Again, context plays a role in determining success ( <b>analysis of the adequacy, effectiveness, and complementarity of the adopted strategies</b> ).	<ul style="list-style-type: none"> <li>🕒 Document review</li> <li>🗣️ Key informant interviews</li> <li>👥 Focus group discussions</li> <li>🏠 MSC workshops</li> </ul>	<ul style="list-style-type: none"> <li>📄 Project documents (especially their theories of change/log frame matrices)</li> <li>📄 Baseline, midterm, and end-term evaluation reports</li> <li>👥 Project staff of implementing organisations</li> <li>👥 National- and district-level health officials</li> <li>👥 Hospital and health centre staff (midwives, nurses, and clinical officers)</li> <li>👥 Village health teams</li> <li>👥 Male and female community members</li> </ul>
3. <b>How effective was the PLA methodology in mobilising communities to participate in the project, learn, and stimulate action on RMNHC issues in their communities? How well were the PLA meetings conducted? What were the challenges in conducting/participating in the meetings? Which stages of the PLA meetings were difficult to implement?</b>		<ul style="list-style-type: none"> <li>🕒 Document review</li> <li>🗣️ Key informant interviews</li> <li>👥 Focus group discussions</li> <li>🏠 MSC workshops</li> <li>📊 Surveys</li> </ul>	<ul style="list-style-type: none"> <li>📄 PLA group session guide</li> <li>👥 Project staff – particularly WCF, UK</li> <li>👥 PLA group members</li> <li>👥 Male and female community members</li> </ul>
4. <b>Was there an increase in referrals to health facilities and improvement in skilled care during labour and birth, and how have these changes informed the district management systems</b>	We believe this is the core of project. It requires us to investigate and find evidence of changes in learning and the use of knowledge/practices in care practices and in maternal and new-born care systems ( <b>policy-level change</b> ).	<ul style="list-style-type: none"> <li>🕒 Document review</li> <li>🗣️ Key informant interviews</li> <li>👥 Focus group discussions</li> <li>🏠 MSC workshops</li> </ul>	<ul style="list-style-type: none"> <li>📄 Baseline, midterm, and end-term evaluation reports</li> <li>📄 Project monitoring logs and annual reports</li> <li>👥 Project staff of implementing organisations</li> <li>👥 National- and district-level health officials</li> <li>👥 Hospital and health centre staff (midwives, nurses, and clinical officers)</li> <li>👥 Village health teams</li> </ul>
5. <b>To what extent have perceptions around pre- and post-natal care changed in the target communities, and how successful were implemented strategies (which included engaging men and older women)</b>	This requires us to trace the changes in perceptions in the target communities as a result of the project interventions, which is a function of the awareness and focused public health education interventions carried out by the project ( <b>change in knowledge, attitudes, and practices</b> ).	<ul style="list-style-type: none"> <li>🕒 Document review</li> <li>🗣️ Key informant interviews</li> <li>👥 Focus group discussions</li> <li>🏠 MSC workshops</li> <li>📊 Survey</li> </ul>	<ul style="list-style-type: none"> <li>📄 Baseline, midterm, and end-term evaluation reports</li> <li>📄 Project monitoring logs and annual reports</li> <li>👥 Project staff of implementing organisations</li> <li>👥 National- and district-level health officials</li> <li>👥 Hospital and health centre staff (midwives, nurses, and clinical officers)</li> <li>👥 Village health teams</li> </ul>



<p><b>6. What hindered or facilitated the implementation of national maternal and new-born strategies in partnership with national governments, local health authorities and frontline health providers</b></p>	<p>We shall focus on the implementation of national policies and systems and on the functionality of structures for delivering maternal and new-born services, which by inference affect the realisation of project impact <b>(systems analysis)</b>.</p>	<ul style="list-style-type: none"> <li>🕒 Systems mapping</li> <li>🕒 Document review</li> <li>🕒 Key informant interviews</li> <li>🕒 Focus group discussions</li> <li>🕒 Survey</li> </ul>	<ul style="list-style-type: none"> <li>🕒 Baseline, midterm, and end-term evaluation reports</li> <li>🕒 Project monitoring logs and annual reports</li> <li>🕒 Project staff of implementing organisations</li> <li>🕒 National- and district-level health officials</li> <li>🕒 Hospital and health centre staff (midwives, nurses, and clinical officers)</li> <li>🕒 Village health teams</li> </ul>
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### Annex 8: Data Tally Sheet

SN	Date of Interview/R eview	Name of Respondent/Source of data	Data collector	1. What impact did the project have on infant mortality and stillbirths, and what facilitated or hindered its implementation (e.g., change in attitudes, overcoming tangible barriers, self-efficacy of women, working closely with health workers, etc.)?	2.Which strategies were the most successful in the implementation of pre and postnatal care practices and skilled delivery (including home care practices, such as exclusive breastfeeding, skin-to-skin contact from birth, early onset of breastfeeding, ensuring babies are kept warm and ensuring basic prevention of infections), and why?	3. How effective was the PLA methodology in mobilising communities to participate in the project, learn, and stimulate action on RMNHC issues in their communities? How well were the PLA meetings conducted? What were the challenges in conducting/participating in the meetings? Which stages of the PLA meetings were difficult to implement?	4. Was there an increase in referrals to health facilities and improvement in skilled care during labour and birth, and how have these changes informed the district management systems?	5. To what extent have perceptions around pre and postnatal care changed in the target communities, and how successful were implemented strategies (which included engaging men and older women)?	6. What hindered or facilitated the implementation of national maternal and new-born strategies in partnership with national governments, local health authorities and frontline health providers?





# POLICY

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