FINAL ENDLINE EVALUATION REPORT

Busia Maternal Newborn & Childhood Survival (MNCH) Project

Mother weighing a child in preparation for immunization at Buwumba H/C II, Dabani Sub-county, Busia.

By

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ChildFund

PROMISE Consult International Ltd

ChildFund Uganda is an International child focused development agency which has been operating in Uganda for over 35 years. ChildFund Uganda is currently operating in 65 districts in Uganda implementing various programs targeting children age 0-5, age 6-14 and age 15-24. ChildFund's core development programs include: Child protection, health, livelihood improvement through provision and support for income generating activities/ initiatives, Early Childhood Development and supporting access to quality education among others. For more information on ChildFund, visit https://www.childfund.org/uganda/

Busia Area Communities Federation (BUACOFE) is a child and youth focused indigenous Non-Governmental Organization (NGO) which started operating in 2008 as registered entity supported by ChildFund International. It is located in Southeastern Uganda 122 miles from the capital, Kampala. BUACOFE is comprised of three (3) community based organizations of Buyengo, Buhasaba and Buhenye which serve five sub counties of; Dabani, Masinya, Buhehe, Lumino and Majanja found in Busia District. BUACOFE was an implementing partner of the MNCH project. For more details on BUACOFE, visit https://buacofe.org/

Promise Consult International Limited was registered by the Registrar of Companies in Uganda in 2011 to provide unparalleled development consultancy services. PCI's primary asset is the team of experts with a rich experience and skills in programme designing, implementation, monitoring and evaluation, strategic planning and institutional development. Strategically, PCI maintains a flexible team of consultants and free to call associates, enabling it to pragmatically respond to the urgent and unique needs of clients.

PCI areas of expertise and competencies include: Strategic planning and management, trainings facilitation and capacity building, Monitoring and Evaluation, Institutional Management and Organizational development, Human Resource Planning and Development.

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This endline evaluation report is a product of the views and perceptions of various stakeholders interviewed. The results and conclusion presented in this report represent the consultants' analysis of respondents' views and perceptions and not necessarily those of Child Fund International- Uganda.

Acronyms/Abbreviations

ADHO	Assistant District Health Officer
BCC	Behavior Change Communication
BUACOFE	Busia Area Communities Federation
CAO	Chief Administrative Officer
CDO	Community Development Officer
CPC	Child Protection Committees
DHO	District Health Office
ELE	Endline Evaluation
FGD	Focus Group Discussion
HUMC	Health Unit Management Committee
LLGs	Lower Local Governments
LQAS	Lot Quality Assurance Sampling
KII	Key Informant Interview
MOH	Ministry of Health
MoU	Memorandum of Understanding
M&E	Monitoring and Evaluation
PCI	Promise Consult International Limited
PDC	Parish Development Committee
S/C	Sub-county
VHT	Village Health Team
WV	World Vision

Executive Summary

For 3 years, September 2017- August 2020, CF implemented a MNCH project in the Busia border district in Uganda whose major aim was to ensure that '*pregnant and postpartum mothers, and children 0 to 2 years of age achieve good health outcomes'.*

In August 2020, Child Fund contracted Promise Consult International (PCI) to assess the results of the project interventions in improving child wellbeing in the targeted communities based on project designed indicators of change.

Here is a summary of the findings of this evaluation.

The evaluation team confirmed- as shown in the table and sections below, using both qualitative and quantitative data that CF succeeded in ensuring that '*Pregnant and postpartum mothers, and children 0 to 2 years of age achieve good health outcomes'* in Busia district. All the indicators returned a positive improvement apart from the one on immunization that fell back by 12% points (from 99.1% to 79.2%). The evaluation team thinks this could have been a source document issue as ideally the data collectors needed to verify the source of information.

Parameter	Baseline	Evaluation
Goal: Pregnant and postpartum mothers, and children 0 to 2 years of age achieve good health outcomes		
Prevalence of childhood illnesses (malaria, diarrhea, malnutrition)	48.3	41.5[1]
Prevalence of maternal and newborn complications	0.0125	0.0137[2]
Outcome 1: Parents have increased knowledge and application of positive pregnancy, postpartum and family health care		
% of women 15-49 who know at least 4 maternal danger signs during pregnancy	14.2%	26.8%
% of women aged 15-49 who know at least 4 maternal danger signs during delivery	3.4%	20.6%
% of women aged 15-49 who know at least 4 maternal danger signs during post-partum	7.1%	19.3%
% of pregnant women who know at least 4 newborn danger signs	2.9%	22.4%
% of parents aware of at least 4 key child family health care practices (infant feeding, immunization, etc.)	14.7%	44.1%
Outcome 2: Pregnant and postpartum mothers and children 0-2 years have increased access to maternal, newborn and child survival interventions		
% of pregnant women who attend at least 4 antenatal visits	69.2%	80.5%
- % of pregnant women who give birth assisted by a skilled provider	79.2%	85.1%
- % of children 12-23 months who are fully immunized	91.1%	79.2%
Outcome 3: Communities engage in planning and managing quality maternal, newborn and child health services		

[1] Source: Busia District Information Management System (DHIS), 2019

[2] Source: Busia District Health Information System (DHIS), 2019

Parameter	Baseline	Evaluation
- % health facilities with active health unit management committees	12.5%	100%

In assessing **stakeholder participation** in this project, this quotation by Busia District Assistant DHO MCH – Sr. Berna Nanyama '*They (Child Fund) have never done anything in this (MNCH) project without beginning and ending with us'* summarizes the magnitude of CF's consultations and involvement of key stakeholders. CF did not only consult but actually used the district structures to implement the project, building their capacity in the process. Direct beneficiaries were equally involved, not only in planning but making contributions, monetary and labor towards implementation of especially the construction works.

From a **project relevance** perspective, CF's MNCH was aligned to the Government of Uganda and the Busia district priorities. Together with the district, CF identified and responded to felt needs on the ground extending services to households living far away from the health facilities. Hasyule health center for example would have temporarily been closed by the district because of its dire state if CF MNCH project had not come to its rescue.

From a **project efficiency** perspective, the evaluation team felt that using the district structures to deliver project activities instead of hiring full time staff overall released resources to meet more direct needs of the beneficiaries. Workload for VHTs for example notwithstanding, it was still more efficient to invest in their capacity building for the long haul. Flexibilities and collaboration with other partners enabled CF leverage resources for reallocation in greater needy areas. However, while CF adopted the governments structural plans for example for the maternity wing, the evaluation team found that CF spent more money in comparison with the district in delivering the same structure.

Effectiveness of sustainability measures. All the three planned sustainability options: implementing through district structures, community participation and CF long term partner BUACOFE were found to be adequate with minor improvements. The VHTs will be able to sustain the project activities even more when the GoU finally formalizes their compensation. Community participation on other hand left out the male involvement while it would have been more effective if BUACOFE was playing a more active role in the project delivery.

The evaluation team noted some recommendations for CF to consider:

- Expanding programming to include adolescent reproductive health. The evaluation team encountered quite a number of teen mothers on the ground – both in the communities and accessing MNCH services at the health centers.
- Establishing innovative models to enhance the role of men in MNCH at household level
- CF to leverage its relationships at district level and innovative programming for more influencing on practice and policy in the sector.

SECTION 1: INTRODUCTION AND BACKGROUND

1.1 About Child Fund Uganda

ChildFund Uganda is an International child focused development agency which has been operating in Uganda for over 35 years. ChildFund Uganda is currently operating in 65 districts in Uganda implementing various programs targeting children age 0-5, age 6-14 and age 15-24. ChildFund's core development programs include: Child protection, health, livelihood improvement through provision and support for income generating activities/ initiatives, Early Childhood Development and supporting access to quality education among others.

1.2 The Maternal-Newborn and Childhood Survival Project

'Maternal-Newborn and Childhood Survival Project in five sub counties of Busia District, Uganda' was designed to address problems related to the maternal and newborn issues in Busia revealed through a needs assessment conducted by ChildFund Uganda and ChildFund Korea in early 2017.

The project was designed to increase parental knowledge on positive pregnancy and child care initiatives. Through intensified community engagement, the project aimed to increase the level of awareness and increase the adoption of the family child health care practices. The demand arising was to match the level of health service delivery by increasing access to facility-based services and at the outreach sites in underserved communities. Furthermore, considering that client perceived quality of care is a key determinant of service uptake, health workers and managers received capacity building initiatives in quality improvement approaches, providing health facilities with maternal equipment. A key emphasis in this project was the setting up of a system to identify and track service defaulters and returning them to care as well as establishing community perinatal and newborn audits.

1.3 Project Goal

Pregnant and postpartum mothers and children 0 to 2 years of age achieve good health outcomes

1.3.1 Project Objectives

i. Parents have increased knowledge and application of positive pregnancy, postpartum and child health care practices
ii. Pregnant, postpartum mothers and children 0-2 years have increased access to quality maternal, newborn and child survival interventions
iii. Communities engage in planning and managing quality maternal, newborn and child health services

1.3.2 MNCH Project outcomes and indicators

Hierarchy of objective	Indicator
Outcome 1. Parents have increased knowledge and application of positive pregnancy, postpartum	% of women 15-49 who know at least 4 maternal danger signs during pregnancy % of women aged 15-49 who know at least 4 maternal danger signs during delivery % of women aged 15-49 who know at least 4 maternal danger signs during post-partum

Hierarchy of objective	Indicator
and child health care practices	% of pregnant women who know at least 4 newborn danger signs % of parents aware of at least 4 key child family health care practices (infant feeding, immunization, etc.)
Outcome 2. Pregnant, postpartum mothers and children 0-2 years have increased access to quality maternal, newborn and child survival interventions	- % of pregnant women who attend at least 4 antenatal visits - % of pregnant women who give birth assisted by a skilled provider - % of children 12-23 months who are fully immunized
Outcome 3. Communities engage in planning and managing quality maternal, newborn and child health services	- No. of health facilities with active health unit management committees

1.4 Expectations of the Evaluation Study

1.4.1 The Objective of the Project Evaluation

According to the terms of reference, the main objective of the evaluation was to assess the results of the project interventions in improving child wellbeing in the targeted communities based on project designed indicators of change, consolidate the project learning especially how the two projects (MNCH and ECD) complemented each other in achieving the planned results. Generate concrete recommendations to inform policy, future practices and programming.

1.4.2 Scope of work of the Evaluation

The study focused on assessing outcomes, effectiveness and efficiency of the project implementation as follows;

1) Evaluate the achievements of the planned MNCH outcomes for children and their caretakers, with respect to the extent to which project objectives were achieved at different results level as specified in the project M&E framework.
2) Assess the level of stakeholders' participation in the project activities; children, Pregnant women caregivers, VHTs, and duty bearers including institutions like schools etc
3) Assess the relevance of the project; to what extent did the project intervention conform to the needs and priorities of target groups; children, caregivers, Pregnant women etc
4) Evaluate the efficiency of the project delivery mechanism, to what extent were the costs of project intervention justified by its results, taking variety of alternatives into account?
5) Evaluate the effectiveness of the project sustainability plan.

SECTION 2. METHODOLOGY

2.1 Introduction

As guided by Child Fund, the evaluation adopted with some changes, the baseline methodology, especially on the sampling criteria and the data collection tools. For this evaluation, Promise Consult adopted the mixed methods and cross-sectional approaches. In addition to the survey, competency assessment, checklists and KIIs for the qualitative data collection, Promise Consult added the Most Significant Change model to document the impact from a more qualitative angle. PCI also expanded the number and categorization of respondents compared to the baseline.

2.2 Sample size and sample selection

2.2.1 Study population

The 5 target sub-counties of Dabani, Masinya, Buhehe, and Majanji in Busia has a total population of 94,630 inhabitants. Beneficiaries included several pregnant women in target area, 176 volunteer health team members, 8 Health unit management committees, 6,000 parents and 10,000 community members.

2.2.2 Sampling and sample size

Quantitative sample and selection

Promise Consult used the LQAS sampling method to determine the respondents for the survey. All the 20 project parishes were the Supervision Lots in which19 respondents were randomly selected in each- a total of **384**. The respondent profile of **households with children aged 0-2 years and women from the second pregnancy onward**. Promise Consult applied the snowball sampling method to identify the 384 respondents fitting into the pre-determined profile. The sampling frame used the VHT lists of the women with children 0-2 years. Once at the respective Parish, together with the VHT or the LC I chair, the consultant identified the first respondent and used that same respondent to identify the next 18 women that were interviewed.

Qualitative data sample and selection

For the qualitative data collection, more purposive sampling was applied. 20% of the health centers were sampled. At district and sub county levels, we interviewed all the Key informants that included the DHO, project implementers at BUACOFE. At sub county level we interviewed the CDO. At Parish level, we sampled 20% of the parishes for KI interviews and talked to the VHTs, Health workers. For FGDs, Promise Consult conducted only one group discussion in each of the 5 sub counties. At Child Fund level, both field and management levels project staff were interviewed. Below is a summary of respondents reached

Table 1: Summary of respondents

Methodology	Method	Tools	Description of Respondents	Number of respondents
Quantitative	Survey	Survey questionnaire (Annex 1)	Women with children 0-2 years, women in second+ pregnancy	384

Methodology	Method	Tools	Description of Respondents	Number of respondents
Qualitative	Key informant interviews	DHT Team KI Guide	Assistant DHO MCH District Bio-statistician	1 1
		KI checklist	CDO	5
		KI checklist	Sub county health workers	2
		VHT guide	VHTs	6
		KI checklist	Health center staff	5
		KI Project implementation guide	BUACOFE and CF	6
	Health facility assessment	Health facility assessment guide	Health unit management	2
	FGDs	FGD guide	Women with children 0-2 years, women in second+ pregnancy	30 (6 in 5 sub counties)
	Most significant change	MSC guide	Women with children 0-2 years, women in second+ pregnancy	Same as the FGD respondents

2.3 COVID-19 considerations

Aware that Busia is a border district that was on a COVID-19 induced partial lockdown during the evaluation, Promise Consult conducted the assessment according to the Standard Operating Procedures issued by Ministry of Health. Child Fund provided clearance and other introductory letters for the consulting team from the National COVID-19 Taskforce. Social distancing, wearing of face masks and use of hand hygiene supplies was implemented to reduce harm.

2.4 Techniques and tools of Data Collection

2.4.1 Qualitative methods

2.4.1.1 Literature review

To provide an overview, context and to corroborate the findings, the consultants reviewed the following documents: District Health sector development plan, District DHIS, the government of Uganda Maternal and Perinatal Death Surveillance and Response Guidelines 2017, the government of Uganda Health Sector Development Plan 2015/16 - 2019/20, records in the respective health centers. Other sources of secondary literature were specific to the project under review i.e. baseline reports, progress reports, proposal document among others.

2.4.1.2 Key Informant interviews (KIIs)

Respective key informant interviews were conducted using a key informant interview guide for each group. For this project in particular KIs were conducted at district, sub-county and parish level as shown in the table 1 above.

2.4.1.3 Competency assessment

The evaluation study adopted the competency assessment tools used at baseline to assess the HUMC.

2.4.1.4 Focus group discussions

An FGD guide was developed to guide discussions with groups of women. Only 5 FGDs were conducted due to COVID-19 restrictions, one per sub-county.

Focus group discussion with women in Buwumba health center

2.4.1 Quantitative methods

2.4.2.1 Household Survey

A household survey was conducted to assess the achievements of the MNCH outcomes for children and their caretakers. The survey tool used during the baseline was reviewed and minor changes made to capture the impact.

2.4.2.2. Digitalised data collection

For the quantitative data collection in particular, the consultants used tablets programmed using XML file format using ODK (Open Data Kit) software. Data collectors were trained and supported to collect data digitally.

Table 2: Evaluation Scope and Data Information Summary

Scope	Tools	Data source
Evaluate the achievements of the planned MNCH outcomes for children and their	• Survey tool • Project reports reviews • Most significant change tool	• Beneficiaries • Lit reviews • Beneficiaries

Scope	Tools	Data source
caretakers, with respect to the extent to which project objectives were achieved at different results level as specified in the project M&E framework.	• KI guide with project staff and other key stakeholders	• Project staff, key stakeholders
Assess the level of stakeholders' participation in the project activities; children, Pregnant women, caregivers and VHTs	• Survey tool • Project reports reviews • Most significant change tool • KI guide with project staff and other key stakeholders	• Beneficiaries • Lit reviews • Beneficiaries • Project staff, key stakeholders
Assess the relevance of the project; to what extent did the project intervention conform to the needs and priorities of target groups; children, caregivers, Pregnant women etc	• Survey tool • Project reports reviews • Most significant change tool • KI guide with project staff and other key stakeholders	• Beneficiaries • Lit reviews • Beneficiaries • Project staff, key stakeholders
Evaluate the efficiency of the project delivery mechanism, to what extent were the costs of project intervention justified by its results, taking variety of alternatives into account?	KI guide with project staff and other key stakeholders	Project staff and other key stakeholders
Evaluate the effectiveness of the project sustainability plan	KI guide with project staff and other key stakeholders	Project staff and other key stakeholders

2.5 Data Management and Analysis

Training of data collectors

A one-day training was conducted for locally sourced research assistants. Part of the training included translating the questions into the local languages. Research assistants largely administered the survey questionnaires while the consultants led the qualitative- KIs and FGD assessments.

Data Management

After the data collection all the digital questionnaires were carefully reviewed and edited. Before the survey data collection all questions were coded to ease analysis. To ease data management, research assistants were allocated to consultants for supervision purposes.

Data analysis (Qualitative and quantitative)
The evaluation team used two kinds of data, the quantitative data from structured questionnaires and checklists, competency assessment tools, KIIs and FGD reports for the qualitative.

Quantitative data was analyzed quantitatively using SPSS. Descriptive statistics i.e. mean was used, 95% confidence intervals, frequency, proportions, percentages, cross tabulations and totals. Measures of variability such as standard deviation were also generated where applicable.

Qualitative data analysis was done using the quality and thematic analysis techniques from key informant interviews. The findings were used to validate the interpretation of the findings from the quantitative studies.

2.6 Reducing Bias and improving data quality
In undertaking this assignment, consultancy team was mindful of enhancing authenticity of the results. Some of the measures taken into consideration included:

i. Random and purposive sampling of the primary respondents as explained above
ii. Employing largely independent data collectors who were 'blindfolded' receiving as little information as possible on the project. From our experience data collectors, if not handled well can unintentionally bias respondents through giving cues
iii. Triangulation, using multiple methods as well as multiple sources of data, cross checking some key issues. Triangulation took place both in terms of comparing and contrasting the responses of different actors but also different modes of data collection – interviews, observation, grey literature, etc. All of these forms of triangulation were means to assess the robustness of findings and to enhance the quality of the research and address attribution.
iv. By going for the digitalized data collection, especially for quantitative data, the quality was enhanced through real time correction and cleaning.
v. Accuracy of translation was addressed by having speakers of local-language as appropriate during interviews and discussions. One of the consultants deployed by Promise Consult spoke the local language (Lusamia) and was therefore instrumental in this process.
vi. Daily reviews with data collectors in the field were conducted.
vii. Supervisors reviewed the digital data captured before being uploaded

2.7 Limitations of the study

i. During the period of evaluation, Busia, being one of the border districts in Uganda was still under COVID19 lock down. While the consultants were given a waiver to collect data, an allotment of only 5 days was allowed. This time was not sufficient to meet all stakeholders. The team resorted to phone interviews in some cases which were not as effective as face to face conversations
ii. Complete lists of VHTs were only obtained for Buhehe and Masinya from Child Fund Staff. Some VHTs were located through the Health Facilities.

SECTION 3: ANALYSIS OF THE FINDINGS

3.1 Basic information on the survey respondents

Category	Endline Evaluation
Head of household	28.6% (110 persons)
Average age	98% of the respondents were in 15-50 years, Below 15 years (0.3%), Above 50 years (1.7%).
Education level	No education (4.4%), Primary school (62.5%), Secondary school (28.4%), Higher education (4.7%)
Occupation	Farmer, fisherman, stockbreeder (42.7%), Housewife (38%), Teacher, Civil Servant, manager (3.6%), Service sales (10.2%), Health worker (1%)
Religion	Christian (93.2%), Muslim (4.7%), Others (2.1%)
Marital status	Married or living together (91.7%), Divorced or separated (2.3%), Widowed (2.3%), Never married or never lived together (3.6%)
Ownership of house	Yes (94.8%), No (5.2%)
Ownership of land	Yes (86.5%), No (13.5%)
Ownership of livestock	Yes (72.9%), No (27.1%)
How old were you when your first child was born?	Majority are 15-50 years (91.9%) and 31 were below 15 years (8.1%)
Who made the decision about your birthplace at the last delivery?	Respondent (56.7%), husband/partner (16.9%), respondent and husband jointly (12.7%), parents in law and parents (8.2%), others (5.5%)

From table above, the endline evaluation, found 98% of respondents aged 15-50 years which corresponds to baseline survey participants average age of 30.7 years thus majority were in Sexual Reproductive age. Most respondents were Christians (93.2%) and Moslems (4.7%), married or living together (91.7%) and have agriculture-related occupation (80.7%), all characteristics were close to baseline survey findings. Only 4.4% didn't attend formal education as opposed to 95.6% with majority attending primary school (62.5%), secondary school (28.4%) and higher education (4.7%). The key issues to note from the survey respondents is that many households had improved conditions of living considering that 95% owned a house, 86% owned land and 73% owned livestock. Compared with the baseline, there were no major socio-economic changes in the study population over three-year project period. However, many

women (8.1%) had first birth when they were below 15 years, indicating a high number of girls are experiencing teenage pregnancies.

3.2 Achievements of the planned MNCH outcomes

To respond to this parameter, an assessment was undertaken to determine the extent to which project objectives were achieved at different results level as specified in the project M&E framework. The assessment was done using both the survey (quantitative) and other qualitative methods.

Findings in this section are presented according to the projects results chain and a comparison made between the baseline and the endline scores

3.2.1 Project goal: Pregnant and postpartum mothers, and children 0 to 2 years of age achieve good health outcomes

To measure the ultimate purpose of the project, two indicators were proposed, that is:

- Prevalence of childhood illnesses (malaria, diarrhea, malnutrition)
- Prevalence of maternal and newborn complications

The evaluation team assessed achievement of these indicators through data captured by the District Health Information System (DHIS) comparing the baseline year (2017) to the endline (2019). According to the biostatistician at the district, the 2020 data was not yet available

There was **a 6.8% drop** in childhood illnesses in Busia district between 2017 and 2019 as shown in table 3 below. However, there was no major change in the maternal and newborn complications. Considering the significant investments by the CF funded MNCH in the district during the period under review to increase utilization of MNCH services, it is safe to conclude that CF's efforts made a contribution to this change.

District level changes

Uganda operates an annual health sector performance assessment dubbed 'District League Table'. By improving quality and health services utilization in the **hardest to reach parishes**, Child Fund contributed to moving the performance of Busia district from #112 in 2017 to #52 in 2019 according to Sr. Berna Nanyama, Assistant DHO in charge MCH. According to her, CF was directly contributing to 6 out of the 19 indicators tracked

Table 3: Goal indicator scores

	Baseline, 2017	**Evaluation, 2019**
Goal indicators		
Prevalence of childhood illnesses (malaria, diarrhea, malnutrition)	48.3	41.5
Prevalence of maternal and newborn complications	0.0125	0.0137

The Government of Uganda, as guided by the WHO framework has classified specific health conditions to determine prevalence of childhood illnesses and maternal newborn complications as shown in the table 4 below. This data is collected and managed monthly by the district local government through the DHIS. The evaluation team averaged the frequencies to determine the difference between the baseline and endline.

Table 4: Showing detailed scores in prevalence 2017 and 2019[3]

	Conditions	**2017**	**2019**
Childhood illnesses	Malaria	124.60%	108.20%
	Diarrhoea	19.70%	15.70%
	Moderate Acute Malnutrition (MAM)	0.70%	0.60%
Subtotal		***145.00%***	***124.50%***
Average		***48.33%***	***41.50%***
Maternal and newborn complications	Severe Acute Malnutrition With Oedema	0.07%	0.06%
	Abortion	1.04%	1.03%
	Haemorrhage related to Pregnancy	0.50%	0.30%
	High Blood Pressure in Pregnancy	0.27%	0.30%
	Malaria In Pregnancy	13.20%	14.60%
	Obstructed Labour	0.70%	0.60%
	Puerperal sepsis	0.40%	0.20%
	Neonatal Jaundice	0.02%	0.04%
	Neonatal Meningitis	0%	0.01%
	Neonatal Pneumonia	0.10%	0.03%
	Neonatal Sepsis (0-7days)	0.30%	0.50%
	Neonatal Sepsis (8-28days)	0.30%	0.26%
	Other Neonatal Conditions	0.40%	0.90%
	Premature baby (as a condition for management)	0.20%	0.40%
Subtotal		***17.50%***	***19.23%***
Average		**1.25%**	**1.37%**

3.2.2 Outcome 1. Parents have increased knowledge and application of positive pregnancy, postpartum and child health care practices

To deliver this outcome CF rolled out a community level BCC strategy on maternal, newborn and child health which was largely delivered through the government of Uganda VHT structure. Significant resources were deployed to develop the capacity of the VHTs through trainings, mentorship to lead this critical activity in changing knowledge and attitudes of parents in the 5 sub counties. To measure change in the target group, 3 indicators were prioritized, that is to say:

- % of pregnant women who know at least 4 maternal danger signs
- % of pregnant women who know at least 4 newborn danger signs
- % of parents aware of at least 4 key child family health care practices (infant feeding, immunization, WASH, seeking care for sick child)

The evaluation team assessed changes in these indicators in comparison with the baseline. Below is a presentation and analysis.

[3] Busia District Health Information System (DHIS)

3.2.2.1 Indicator 1: % of women age 15-49 who know at least 4 danger signs during pregnancy.

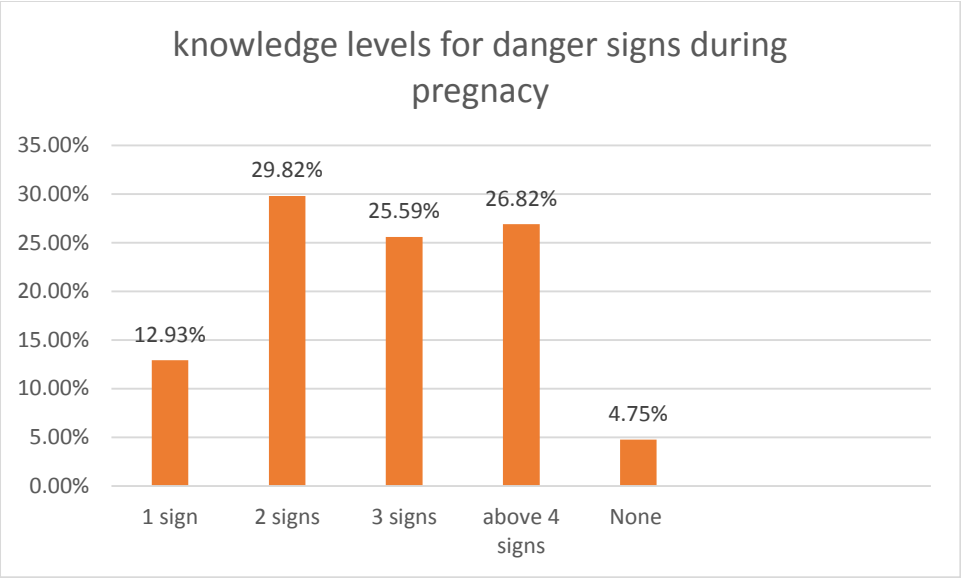


Figure 1: knowledge levels for danger signs during pregnancy

The survey showed that 26.82% of women (15-50 years) know at least 4 danger signs during pregnancy. While this represents just a quarter of the sample and much lower than the national average of 30% (UDHS Survey, 2016), the evaluation finding demonstrates that CF **increased the number of women knowledgeable** on the danger signs (at least 4) during pregnancy by **12.6%** compared to the baseline. Three years earlier, only 14.2% of the women sampled could name at least four danger signs during pregnancy. Additionally, 7% were not able to name any danger at all during the baseline compared to 4.7% in the evaluation.

Table 5: Details of Danger signs during pregnancy known

Sign that is most known	**percentage**
Bleeding	57.0%
Severe headache	45.9%
Blurred vision	45.6%
Convulsions	41.2%

Of the top four common signs named by respondents in both the evaluation and the baseline, only two appeared in both assessments: bleeding and headache and both showed an increase from 32.6 % to 57% and 28.2% to 45.9% respectively. What is interesting to note, however, is the expansion in the knowledge of additional danger signs specifically blurred vision and convulsions which had both recorded less than 5% in the baseline. This could mean that the sensitizations at community level served to increase and expand the knowledge.

By sub counties, the result shows that between sub counties there is statistically significant difference on the knowledge level. (F=12.222, df=5;379, p<0.05) With the highest average knowledge level in Dabani sub-county (mean 2.78, Std 0.97) and the lowest in Lumino sub county (mean 1.82, std 1.174). We note that Dabani Sub-county is near Busia Municipality, hence this could have also contributed to the easiness by which the community were mobilized to engage in the project activities.

3.2.2.2 % of women aged 15-49 who know at least 4 danger signs during delivery.

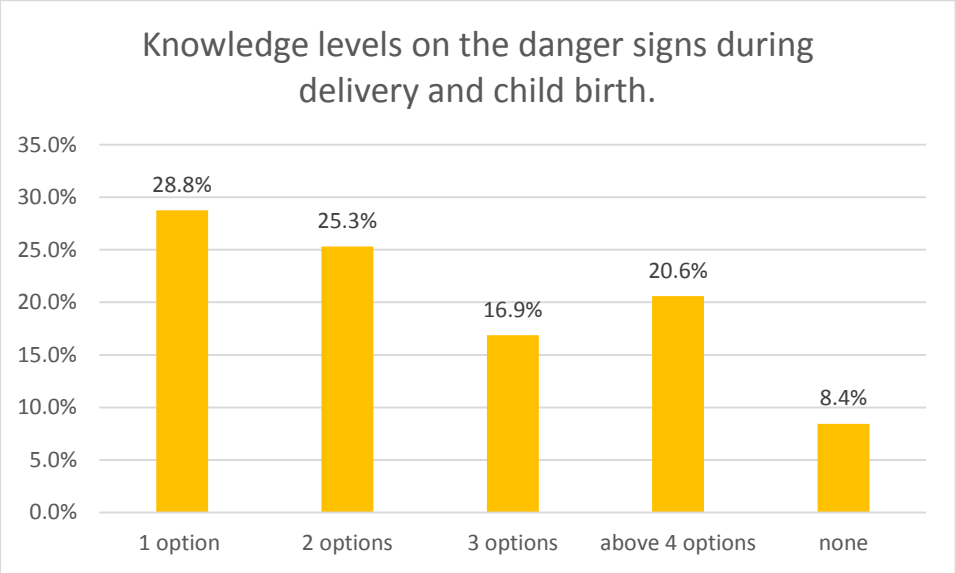


Figure 2: Percent of women who know 0, 1, 2, 3, 4 and above danger signs during delivery.

Figure 2 indicates that 20.6% of mothers knew at least 4 dangers signs during delivery, representing **a 17.2% increase** from the baseline figure of 3.4%. On other hand, about 8% of the women did not know any danger signs during delivery, which seems to have gone up from the 5% recorded during the baseline survey.

Table 6: Danger signs during labour known

Danger sign	percent
Severe bleeding	67.4%
Labor lasting over 12hours	46.4%
High fever	33.1%
Placenta not delivered 30 minutes after baby	31.8%

Expanded knowledge to include retained placenta as one of the danger signs during labour was picked up during the evaluation. This particular danger sign was not among the top 3 in the baseline. This could mean there was increased sensitization during the ANC and community meetings. Overall, we note that across the board, the level

of awareness by the women about the danger signs during delivery did significantly increase during the project period.

By sub counties, the result shows that between sub counties there is statistically significant difference on the knowledge level. (F=9.648, df=4;379, p<0.05) With the highest average knowledge level in Majanji Sub-county (mean 2.65, Std 1.424) and the lowest in Lumino sub county (mean 1.46, std 0.944).

3.2.2.3: % of women aged 15-49 who know at least 4 dangers signs during postpartum.

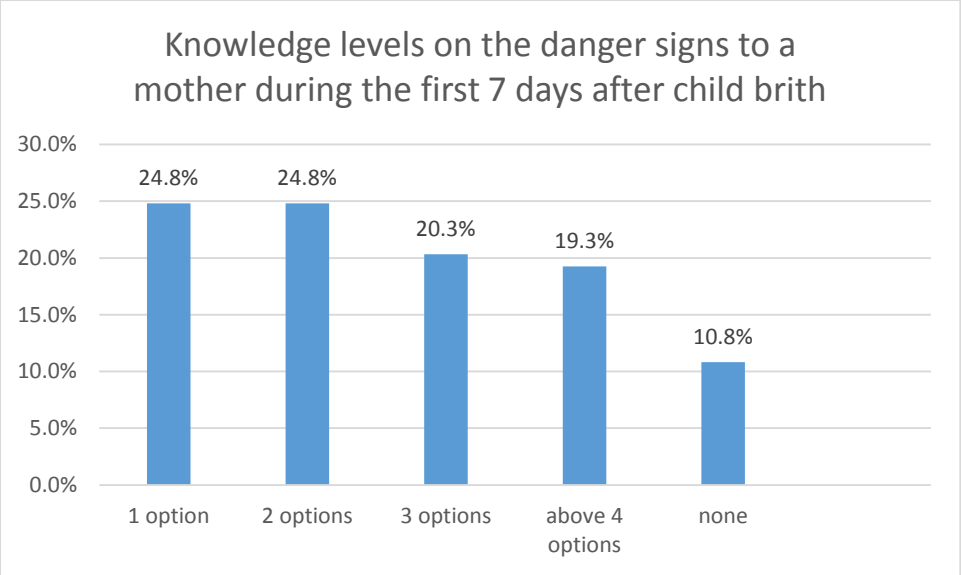


Figure 3: knowledge levels on danger signs in post-partum

Figure 3 shows that the more the danger signs during post-partum, the less the number of women with knowledge. Indicator 3 was specifically measuring the percentage of women knowledgeable in at least 4 danger signs. While the evaluation findings showed only 19.3% of the women could name 4 danger signs during post-partum, this was a significant increase of 12.2% in comparison to the baseline. Three years earlier, only 7% of the women knew at least four signs. What is equally interesting is the drop in the number of women who knew at least two signs, from 41.8% during baseline to 24.8% during the evaluation.

Table 7: Danger signs in post-partum

Danger sign	percent
Severe headache	67.2%
High fever	38.5%
Severe weakness	36.5%
Smelling vaginal discharge	30.2%

While there was an increase in number of women naming the top 3 danger signs: severe bleeding, high fever and severe weakness between the baseline and endline, what is interesting was the expansion of knowledge to include smelling vaginal

discharge. 30% of the women could name this during the evaluation but the same danger sign was not mentioned among the top 4 common ones during baseline. This is another testimony of increased and more comprehensive sensitization received that could be attributed to the project.

By sub counties, the result shows that between sub counties there is statistically significant difference about the knowledge level. ($F=13.424$, $df=4;379$, $p<0.05$) with the highest average knowledge level in Majanji sub county (mean 2.78, Std 1.247) and the lowest in Lumino sub county (mean 1.49, std 1.125). No analysis was done within sub counties to make comparisons in Parishes.

3.2.2.4. % of women age 15-49 who know at least 4 newborn danger signs

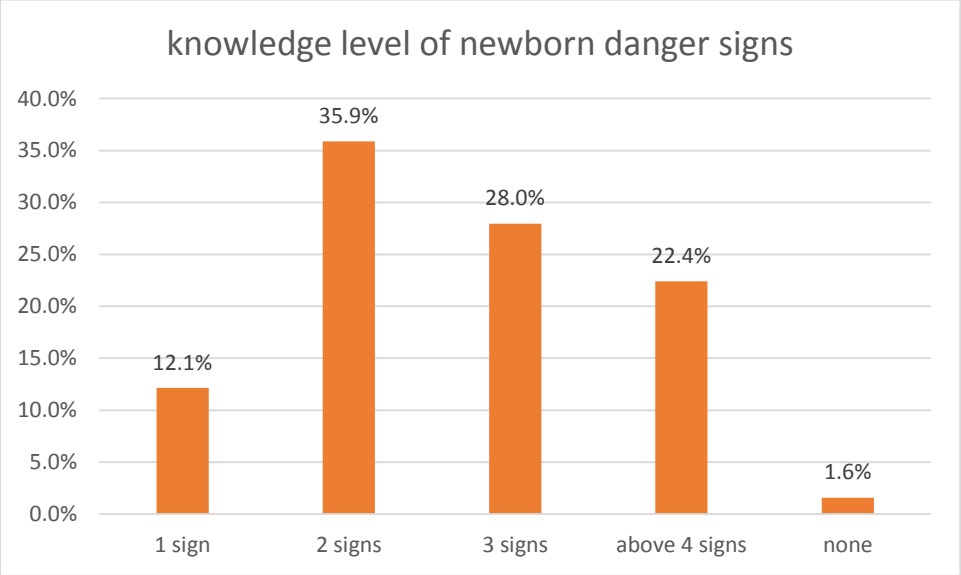


Figure 4: Percentage of women who knew 0, 1, 2, 3, 4 and above newborn danger signs

Figure 4 above shows that 22.4% of the respondents knew at least 4 danger signs in newborns. Majority of mothers 35.9% were able to identify 2 danger signs in newborns. Compared with the baseline survey findings, the CF funded MNCH project contributed to increasing the percentage of women knowledgeable in at least 4 danger signs of new born by 19.5%.

Table 8: Known danger signs in newborns

danger signs	percent
Feel hot/fever	79.4%
refused to breastfeed	57.5%
has pus blisters on the skin	44.1%
difficulty in breathing	40.1%
umbilicus red/discharging pus	38.3%

At close to 80%, a majority of the mothers knew fever as a danger sign among new born followed by refusal to feed. The top mentioned danger signs in newborns did not differ much between the baseline and endline. Additionally, a significant change in frequencies between the baseline and evaluation was registered across the board. For example, 51% cite fever in the baseline but this jumped to 79.4% at endline, similarly 33.7% cited refusal to feed at baseline but this increased to 57.5% and 26% mentioned difficulty in breathing at baseline but the evaluation recorded an increase to 40%.

The evaluation went further to test if VHT home visits after child birth was directly correlated with knowledge of danger signs of new born. From the analysis below, we find no significant impact of VHT home visits to knowledge on new born danger sign as those visited and those not visited had similar knowledge.

Report count for 29

27_20_During_the_fir	Mean	N	Std. Deviation
VHT visit group	2.58	219	1.030
VHT non visit group	2.55	165	1.021
Total	2.57	384	1.025

3.2.2.5. % of women aged 15-49 who are aware of at least 4 key child family health care practices.

Table 9: Key child family health care practices known

Number of key child family health care practices known	**percent**
1 key child family health care practice.	8.2%
2 key child family health care practices.	15.3%
3 key child family health care practices.	32.5%
Above 4 key child family health care practices.	44.1%

Among the knowledge indicators, awareness on key child family health care practices received the highest rank at 44% of the women able to name at least 4 key child family health care practices as shown in table above. Relatedly, in comparison with the baseline with only 14.7%, this indicator showed the highest increase of 29.4% of the women who could name at least 4 key child family health care.

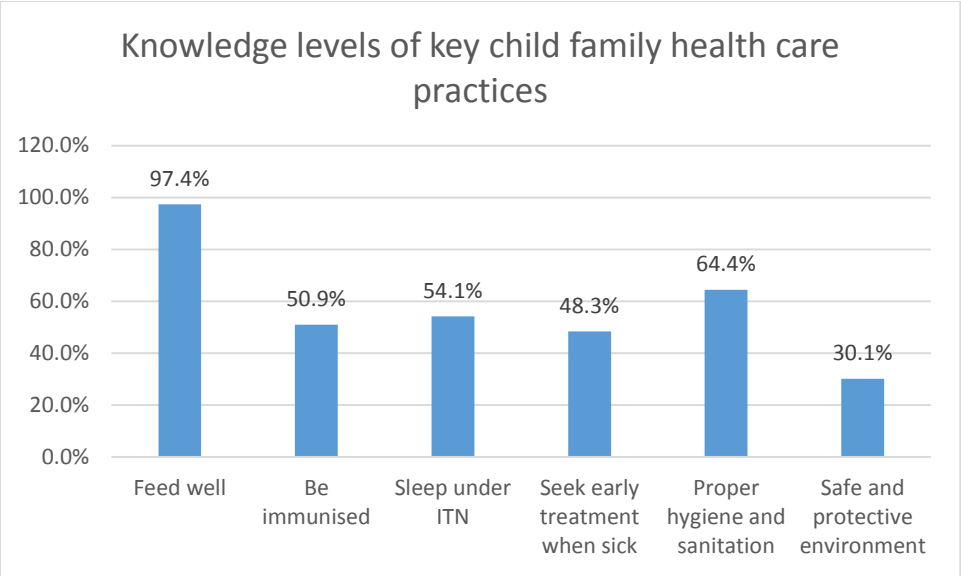


Figure 5: % of women aware of 0, 1, 2, 3, 4 and above key child family health care practices

This indicator investigated further the examples of key child family health care practices, including knowledge and practice in breastfeeding.

Among the child family health care practices, feeding well and proper hygiene were the commonly named. This was similar to the baseline only that the endline scores, particularly on proper hygiene were higher at 64.4% compared to 43.7%. What is interesting to note is the relatively smaller number that named immunization and sleeping under an ITN some of the key health messages received during ANC.

Knowledge of breastfeeding.

The number of women interviewed that knew that the correct time to introduce a child to the breast was within the first hour increased from 70% during the baseline to 85.5% during the evaluation. This might be attributed to the health education in the community by VHTs and the health staff during ANC.

By sub counties, the result showed that between sub counties there was no statistically significant difference on the knowledge level. ($F=3.823$, $df=5;379$, $p>0.05$), with the highest average knowledge level in Majanji sub County (mean 3.33, Std 0.964) and the lowest in Masinya sub County (mean 2.82, std 0.884). These results are probably due to the fact that Masinya sub County is most remote and hard-to reach amongst the 5 sub Counties in which the project was undertaken.

Table 10: Period after birth a mother initiate a baby on the breastfeeding

How long after birth should a mother initiate a baby on the breastfeeding?	**percent**
1 = Within one hour	85.5%
2 = Within one day	10.3%
3 = After one day	1.1%

Other areas investigated that was related to proper child and family care practices included length of breast feeding. 67.8% of respondents exclusively breastfeed their children for the first six months as recommended by the WHO and the GoU. However, this was much lower than the baseline that recorded 84.7% of respondent's breast feeding exclusively for 6 months. It is probable that the difference here is due to the phrasing of the question. It is difficult to succinctly explain this. It might be the interpretation of the question.

3.2.3 Outcome 2. Pregnant, postpartum mothers and children 0-2 years have increased access to quality maternal, newborn and child survival interventions

Deliverables in this outcome were largely geared towards improving quality of services at the health facility and health sub district levels. Apart from training in quality improvement, equipping of health facilities for skilled birth attendance, the project also rolled out a system for newborn death notification and audits. Three indicators were defined to measure this outcome:

% of pregnant women who attend at least 4 antenatal visits
% of pregnant women who give birth assisted by a skilled provider
% of children 12-23 months who are fully immunized

Findings in each of these indicators are presented below;

3.2.3.1 % of women aged 15-49 who attend at least 4 antenatal visits

The GoU has adopted the WHO recommended 4 antenatal visits as a standard for pregnant women checkups. The evaluation reported that 80.5% of the women actually go for at least 4 ANC visits. The CF funded project contributed to increasing this number from 69.2% that was recorded during the baseline. Of those that didn't go for ANC, the reasons were around awareness on scope and cost of services in the nearest health facility. Two people noted distance as the barrier

CF directly intervened in both the supply and demand spectrums of MNCH services that contributed to increased utilization of the services. Sometimes utilization of ANC services was accompanied by incentives such as mama kits, follow up by the VHTs among others. One of the respondents of an FGD had this to say:

> *'I had delayed to start ANC, but one day our VHT found me home. I was 6 months pregnant at the time. The following day I came to the health center for the ANC'.* - Catherine Sanya, a mother of 6 months baby- Buwumba parish.

> *'If it wasn't for CF, deliveries would not have started in this health center this soon'* Dinah Alepus, the midwife in Buwumba health center II
>
> According to the interview, CF equipped the Health Center II with the necessary MNCH equipment and lighting to enable safe deliveries. Deliveries began in January 2020 in an old structure as the maternity wing was being constructed. By August, 12 safe deliveries had been conducted at the center.
>
> CF's support also led to increase in ANC service utilization, both facility based and during outreaches in this hard to reach parish. At the end of 2018 (when the midwife was posted to the center) approximately **2** mothers came for ANC on a monthly basis but this had increased to **60** mothers by the time of the evaluation. According to Dinah, CF directly contributed to this outcome though the targeted outreaches and sensitization of the community about available services.

For this particular mother, she had delayed to start ANC first because it was a 'surprise' pregnancy and secondly because had bounced 3 times at the health center.

3.2.3.2. % of women aged 15-49 who give birth at health facility

While 80% of the women interviewed attended at least 4 ANC visits, a bigger number- 85% had their childbirth and delivery at Health facilities, a majority (77.6%) of which were in government aided facilities. There was a slight increase in the number of women giving birth in the facility from the baseline value of 79.2%.

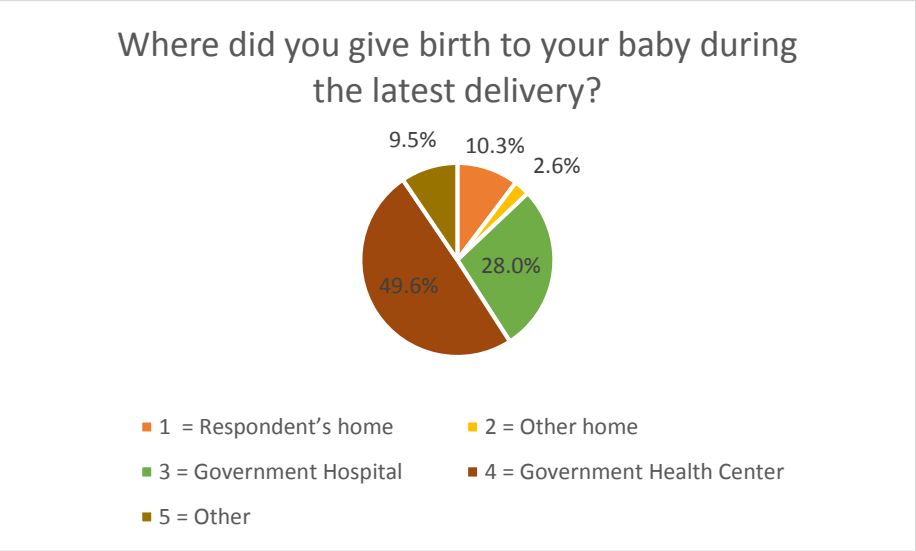


Figure 6: Locations of birth

From the survey, a majority of the women noted that 'abrupt labour' and close proximity to private health center and distance as barriers to delivering at the health centers. Part of these findings were substantiated by the FGDs in addition to newer issues that came up. The Hasyule parish FGD in particular, women felt that there are still pockets of misinformation in the community about advantages of delivering in the health facility. In addition, some facilities are indeed far with women having to travel for up to 10km to the health facility especially in Lumino and Masinya sub counties. This point was emphasized by one participant during the FGD at Hasyule HCII, Lumino sub-county who complained of the long distance of 9km from her home to the nearest health facility as well as poor services.

No. of ANC visits	**% score**
# of times: 1	0.53%
# of times: 2	2.37%
# of times: 3	14.78%
# of times: 4	80.47%
# of times: None	0.53%
88: DON'T KNOW	1.32%
Grand Total	**100.00%**

'One time I came to the health facility and due to limited number of staff, I ended up spending the entire day at the facility and only saw the health care personnel at 3pm!'

Another interesting but unique barrier was the impact of the COVID-19 restrictions on access to and use of health services. For example, in the Buwumba parish FGD, 3 women with babies less than 6 months who gave birth at home cited COVID-19 curfew induced regulations as a deterrent.

Immunization score in CF supported centers

The MoH uses a 1-4 grade system to assess and categorize access, utilization and completion of immunization at facility level. Category 1 means the facility is scoring in all the 3 parameters: children are accessing, using but most importantly completing the immunization schedule on time. According to the Busia assistant DHO in charge MCH, CF project intervened to increase immunization in 4 remotest parishes in Busia district. By the end of the MNCH project, these 4 health centers had moved to first place except for Buhehe as shown in the table below:

Health Center	Category	
	2017	2019
Buhehe	4	3
Buyengo	4	1
Hasyule	4	1
Buwumba	4	1

Table 12: Reasons for not choosing to deliver at health facility

Reasons for not choosing facility	**percent**
1 = I did not have a transport to the health facility	21.2%
2 = Facility was too far	12.9%
3 = I thought services are poor at facility	3.5%
5 = I did not think it was necessary	10.6%
6 = Family members did not think it was necessary	1.2%
7= Others	50.6%
Total	**100.00%**

Reasons for the other alternative to delivering at health facility are; it was abrupt delivery, (40%) and/or the private hospital or NFP was nearest to the respondent (23.8%)

From the perception score, women in both the survey and FGDs have a favorable perception of the health facilities. For example, 99% would consider going for ANC in next pregnancy and deliver from health centers. There was a slight challenge though on perception of treatment to be received at the health center. While 96% believed health workers were skilled, 92% thought they treated women with respect. Other barriers were on adequate staffing (48.6%) and medical supplies (46.2%). Details of the perception score is in the annex 4. Clearly there are some issues that are beyond the projects control such as staffing.

3.2.3.3. % of children 12-23 months who are fully immunized

For a child to be fully immunized, it is necessary to have at least 4 visits to the health facility. Therefore, when visits are more than 4 times, they are assumed as fully immunized. In this survey, 79.2% of the children aged 12-23 months were immunized 4 and/or more times. Interestingly almost half (48.5%) were immunized 6 times.

Of the 79% respondents, 69% answered immunization card as their source of information.

This is the second indicator that returned a negative result from the baseline comparison. During the baseline 91% of the children aged 12-23 were reported as having received at least 4 immunization shots. However, baseline report noted "*it is assumed that either enumerator missed to check with an actual card or the memory of the respondents is not accurate. In this context, though 80 percent of women answered immunization card as their immunization information source, it is not fully clear if it is checked with actual immunization card*".

3.2.4 Outcome 3. Communities engage in planning and managing quality maternal, newborn and child health services

Interventions delivered by CF for this outcome were more at the health center management level. To that effect, HUMC committees were trained and facilitated to conduct feedback and action planning meetings with communities to improve the quality of health services.

Only one indicator was stated to measure this outcome.

3.2.4.1 Number of health facilities with active health unit management committees

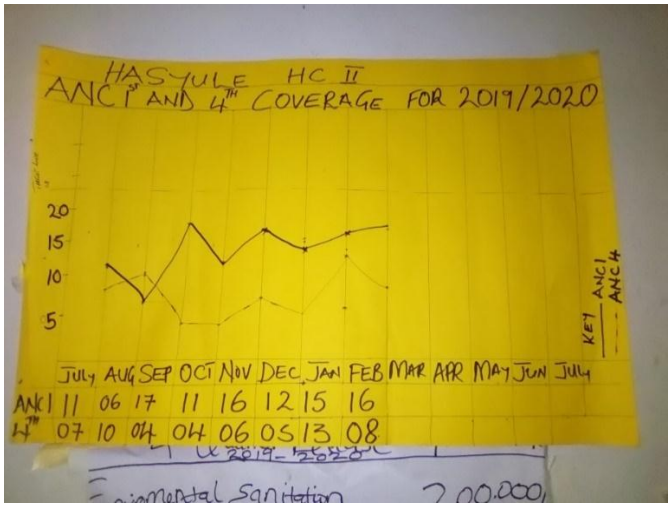
According to the MoH guidance only 4 indicators are used to assess functionality of a HUMC. 1) Composition according to the guidelines, 2) knowledge and practice of roles and responsibilities in oversight such as supervising financial management, approving budgets, approving work plans, 3) functionality, measured by number of meetings (with documented minutes) held in a quarter and 4) capacity building by trainings received.

Only 3 health centers were randomly sampled for the evaluation assessment. As compared to the baseline, **all the 3 were found fully functional** as shown in the table below. Evidence was seen by the evaluation team on all the indicators. Meetings were regularly held, at least once a quarter. Amongst the issues discussed during these meetings were; payment for VHTs, lobbying for rehabilitation of maternity ward at Hashule and Buwumba HCIIs. Sensitization campaigns on male involvement in antenatal and delivery services were also held. In some health centers such as Buwumba, capacity building was done by more than just CF, even World Vision was reported as having trained the HUMC.

Table 5: Comparison of functionality of HUMC before and after the project interventions

Category	Baseline			Evaluation		
	Hasyule	Majanji	Buwumba	Hasyule	Majanji	Buwumba
	H II	H III	H II	H II	H III	H II
Composition	1		1	1	1	1
Roles & Responsibility	1	1	1	1	1	1
Function	1	1		1	1	1
Capacity building	1			1	1	1

Below is an example of records kept by the Hasyule health center II as overseen by the HUMC



Most significant story

Nafula Brenda is a mother of three, eldest being 6 years and youngest 9 months. This is her story. 'I learnt of this Child Fund project when our VHT – Nabwire Jackie mobilised people of Boyodi A village for sensitization caring for children and deworming. After attending the community meeting, I also brought my children for deworming and later when I became pregnant I attended ANC at Hasyule HC II. From this project, I learnt to clean myself before breast feeding my baby. I also joined a support group where we learnt more about pregnancy and new born health. Through this group, we were supported to plant trees. The most significant change for me was to ensure I attend ANC at least four times, exclusively breast feed my baby for the first 6 months and ensure he finishes the immunization schedule. Even today the baby is 9 months and I had brought him for the measles immunization. My children are now healthier and growing up better than before. I am a happy mother.

Child delivery services brought closer

Taaka Joy, aged 38 is a mother of 3. She was among the very first mothers to deliver in Buwumba health center II. She delivered on the 7th of February.

Picture above, Taaka with her baby

This is her story.

'Deliveries starting to take place in this health center has been a relief. All of us here used to move up to Masafu hospital, approximately 5kms away. You either had to walk or look for money to pay the boda boda (motorcycle taxi). I enjoyed my pregnancy with this baby, Buwumba health center is less than 1/2km away. I had all my ANC visits there. And it was difficult to skip the visits because VHTs also move in the villages to check on pregnant women. During the ANC, we were told that actual deliveries were going to start at the center because Child Fund had donated equipment. So on the 6th February, when my labour pains began, I just moved to the center. That night I was the only woman in labour but there was light in the ward. The midwife also treated me well. I have also been taking the baby for immunization. There are now 3 health workers at the center, if the government can add us some more two workers all the challenges will be solved because I know once the new maternity wing constructed by Child Fund is in use, there will be more women using the maternal services'

3.3 Stakeholders' participation in the project activities

By design and by implementation, the evaluation team was able to confirm cross stakeholder participation in the implementation and monitoring of the CF funded MNCH project.

3.3.1 Duty bearer participation

CF and BUACOFE meaningfully involved both the political and technical staff at the district and sub county level in the planning and delivery of the MNCH project

For example, identification of priority locations was not only determined by the district plan, according to the DHOs office, the CF and BUACOFE team held meetings with them to select the neediest locations to target, which included jointly conducted assessments.

Additionally, the local government technical team was involved in the actual delivery of the project through their respective staff at different levels such as the VHTs, health assistants, the DHT, the district engineer among others. Some NGOs would ideally employ technical staff and only involve the local government in planning and consultations. By involving the same team in the planning and actual delivery, CF chose a more detailed and meaningful participation of this key stake holder group in a project.

For oversight and quality control, CF organized joint monitoring visits comprising of both the political and technical staff to assess the interventions at the different health facilities and communities targeted by the project. In one monitoring visit, the Chief Administrative Officer (the highest accounting officer for the district) was named among the team that went to the ground to see the work by CF.

Another form of participation found by the evaluation team was through Health worker joint performance reviews held quarterly and chaired by the district. These reviews brought together parish, sub-county and district government and non-government stakeholders to assess and plan for improved quality of services. The acting CDO Dabani sub county, shared her experience of attending a review meeting once. She thought this was an innovative performance enhancing exercise undertaken by CF. According to the MNCH project officer, 2 health workers who were commuting instead of residing in Bumunji health center II were put to task to explain their performance. Thereafter, they had to reside in the health center thereby being more available to serve the community.

> *'They (Child Fund) have never done anything in this (MNCH) project without beginning and ending with us'*
>
> Busia District Assistant DHO MCH – Sr. Berna Nanyama

3.3.2 Beneficiary participation

The evaluation team found concrete examples of beneficiary participation on the ground.

All construction works involved some form of community contributions in form of labour, cash and/or local materials. Of all the constructions undertaken in the MNCH project, the biggest was the construction of the Buwumba health center II maternity wing. According to the focus group discussions, the community agreed to mobilize Ugx 1 million (approx. $270) as a co-contribution to the construction works. Each family contributed just under $1 (Ugx 3,000). In addition, a committee to supervise the construction works was instituted. The evaluation team verified daily supervision of the construction through the project tracking book at the site.

Newly constructed and fenced maternity wing in Buwumba Health Center II. The community contributed labour and cash of approximately $270

3.4 Relevance of the MNCH project

In assessing the relevance of the project, the evaluation team analysed the extent to which the project interventions conformed to the needs and priorities of target groups; children, caregivers, pregnant women, the government of Uganda among others.

3.4.1 Felt needs on the ground

According to the interviews conducted, the CF funded project was implemented in underserved and sometimes hard to reach locations such as Buyengo, Hasyule and Buwumba.

'The government had failed to equip these facilities for a long time' the DHO MCH noted in an interview.

Moreover, for many of these locations, mothers used to trek long distances for appropriate MNCH services. In Buwumba parish, the nearest was Dabani Hospital a Private missionary hospital that required user fees to access any service. The alternative was for the mothers to move 5km away to Masafu, the only government hospital in the sub county.

Hasyule H/C II saved from closure

In 2018, a heavy bats infestation and dilapidated structures had led the government to strongly consider temporarily closing the Hasyule H/C II. In fact, during the assistant DHOs monitoring visit, she decreed the closure. Fortunately, when CF introduced the new MNCH project to the DHTs office, the joint needs assessment conducted prioritized Hasyule for a major renovation.

In addition to the dilapidated state of Hasyule health center II, the remoteness and insecurity from across the border (parish neighboring Kenya) made it extremely difficult to attract and retain health workers. The renovation, fencing and lighting through the CF MNCH project improved overall service delivery in the health center as the health workers willingly resided in the premises.

Child Fund used multiple approaches relevant to different contexts to increase access to the much needed MNCH services. In parishes such as Buwumba with distant villages, community outreaches to serve women in the furthest locations were undertaken.

3.4.2 Alignment to government priorities

Another legitimate representation of needs on the ground is the government plans. As a duty bearer, it is assumed that any priorities in government plans have gone through legitimate identification processes, taking the needs of the rights holders into consideration. The evaluation team therefore reviewed relevant plans to ascertain coherence with the CF funded MNCH project.

At the national level, the CF MNCH project contributes to achievement of strategic intervention 1 that aims for *Health promotion across the life course (RMNCAH and elderly)* under strategic objective 1 of the Uganda Health Sector Development Plan 2015/16 - 2019/20.

The innovative activity on maternal and perinatal death audits was a direct implementation of the Maternal and Perinatal Death Surveillance and Response Guidelines 2017. Through the CF funded project, Busia district was among the first districts in Uganda to roll out these guidelines. The government of Uganda only managed to initiate implementation of these guidelines in 2020 according to the Assistant DHO, Busia district.

At the district level, the evaluation team found that the CF funded MNCH project falls under the top 3 specific objectives of Busia District Health Services Approved Five Year Development Plan 2015/2016 – 2019/2020. These included: 1) to increase

access and utilization of available health services, 2) to maintain a high coverage of 95% and above for routine immunisation for DPT3, BCG and 3) Reduction of maternal and infant deaths. Additionally, of the 8 health centers targeted by the project, 5 are prioritized in the district work plan.

3.5 Efficiency of the project delivery mechanism

This section assesses the extent to which the costs of project interventions were justified by the results, taking a variety of alternatives into account

3.5.1 Project delivery structure

To implement this project, CF deployed an extremely thin structure by design. Project staff were only up to the district level and the lower level activities implemented through government structures. For example, instead of recruiting technical experts such as engineers to oversee construction works, CF preferred to use the district engineer. Instead of a project staff at community level the VHTs were used. The immediate benefit from such a structure was the significant reduction in the staff costs as all CF did was meet facilitation fees. The alternative to a VHT structure would have been a trained project staff at sub county level, however, such would remain available only up to the end of the project. While there were cases of workload for these structures especially VHTs due to multiple reporting lines, the ultimate decision to build capacity of and anchor activity delivery to government structures delivered a more compounded and sustainable impact as they remain resident in the district and communities.

> '*Before the MNCH project, we never visited homes for pregnant women and mothers of children below 2 years'*- Apio Joyce VHT, Bunyide village, Buhehe sub county

Apart from the district structure, the role of BUACOFE, CF's long term partner in the implementation of the project was not clear. And yet this might be the strongest sustainability ally for the project. An interview with Okotch Edwin a Community Development Facilitator Buyengo community could not articulate a clear role played in the project except sometimes delivering supplies to the VHTs.

3.5.2 Capital investment costing

The evaluation team found that CF commonly adopted government endorsed structural plans for most of its construction works. The maternity wing in Buwumba for example was built according to the government structural plan. However, with a contract sum of approximately Ugx 280m according to BUACOFE Area Manager, CF spent more than what Busia district spent in a similar structure at Bulumbi health center III at the beginning of 2020. The district spent Ugx 235m as shared by the DHOs office.

3.5.3 Collaboration

CF was working within a context that of many actors in the health sector. From the DHO's interview, 7 development actors were intervening in health in Busia district during the MNCH project lifespan. These included Rhites EC, Marie Stopes, PSI, PES, Uganda Cares, World Vision and Child Fund. Of these, WV and CF were more specific to MNCH. Regular coordination meetings were conducted among partners for cross planning, information sharing and reduction of duplication, ensuring resources are efficiently used. During this process, some project activities were jointly implemented or major adjustments made.

Efficiencies from coordination

When CF received funding to implement the MNCH project, World Vision was also implementing another MNCH project. During the information sharing, CF, according to the Project Officer MNCH discovered that just like them, WV had a budget line for mobile health, an activity to digitize VHT functions. While CFs target was 5 sub counties, WV had resources to cover the entire district. CF decided to drop the activity altogether, saving Ugx 56m which was later re-allocated to renovate Hasyule Health Center II, an equally pressing need.

However, the coordination and collaboration did not entirely remove duplication. The evaluation team found that two solar systems were nonfunctioning at the time of the evaluation in Hasyule and Majanji health centers. In both cases, the issue had not been reported to the district where it would have been possible to access PHC funding to make any repairs. Of interest is that Hasyule had received a bigger solar installation at the beginning of 2020 from the Ministry of Health through the DHOs office. According to the midwife of Hasyule, the issue (broken down solar) had not yet been reported to DHO Office.

3.5.4 Flexibilities in implementation

The funding and implementation flexibilities within the overall CF funding framework especially access to the non-sponsorship fund supported the accomplishment of the project activities leading to increased efficiencies. There were many examples of the non-sponsorship fund complemented the project to deliver some critical deliverables which otherwise would have undermined the overall project outcomes such as the Buwumba health center II maternity wing.

The evaluation team also documented cases where the implementation team. For example, according to the 2019 annual report, a VHT assessment exercise in one of the quarters was stayed and the budget allocation used to procure tools that the VHTs had identified in an earlier assessment as necessary to help them be more effective.

3.5.5 Timeliness of activities

The project implementation team was keen on planning to ensure timeliness. Quarterly plans were reviewed and necessary adjustments done.

> '*the only delay reported was at the beginning of the project which was spent setting up relevant structures and logistics, but after that the implementation made up for the lost time'*. Irene, MNCH Project Officer

The Buwumba maternity wing that should have been completed by April construction having started in November the previous year was not fully completed and handed

over to the district by the time of the evaluation. However, this delay, according to the implementation team was because of the COVID-19 disruptions.

A summary of major output accomplishment is presented in the table 6 below.

Table 6: Summary of major Project Outputs accomplished against Targets

Outputs	Indicator	Achievement Cumulative	Target	Achievement rate (%)
1.1. Community health workers capacity strengthened	No. of VHT members trained on maternal and child survival interventions	344	176	195.5
	No. of VHTs with equipped with printed behavioural change communication materials	344	176	195.5
	No. of VHT performance reflection meetings held	34	48	70.8
1.2. No. of VHT performance reflection meetings held	No. of community dialogue meetings held	114	88	129.5
	No of parents reached	8,273	6,000	137.9
2.1. Quality improvement teams established at health facilities	Health facilities satisfy maternity care quality standards	8	8	100
	No. of health facilities with functional newborn audit committees	7	8	87.5
2.2. Health infrastructure for maternal, newborn services supported	No. of health facilities provided maternity equipment & supplies	8	8	100
	Maternity ward constructed & equipped at Buwumba HC II	1	1	100
2.3. Community outreach sessions held	No. of community outreaches conducted	336	240	140
	No. of participants reached	9,148	10,000	91.48
3.1. Health unit management committees strengthened	No. of health units with HUMC trained in community health management	7	8	87.5
	No. of health unit management committee meetings where quality of care was discussed	80	80	100
3.2. Community dialogue meetings on quality of health care held	No. of community dialogue meeting held	56	80	70
	No. of participants attending meeting (by gender/leadership /roles	2878	2,000	143.9

Source: MNCH 1st and 2nd year Annual and Progress Reports from July 2017 to April 2020[4]

3.6 Effectiveness of the project sustainability plan.

According to the MNCH project proposal, CF had planned to increase sustainability of this projects outcomes through three major strategies

- Implementation through district structures
- Community participation through the HUMC
- The presence of a long term implementer local partner in the project area

[4] To be updated after compilation of 3rd Year Annual Report.

3.6.1 Implementation through district structures

The bulk of the project delivery was through the VHT structure. CF invested significantly to build the capacity of this structure that has been integrated into the government health systems as Health Centre I. As a community based structure, fully resourced by government and non-government partners, means they will most likely continue to support the MNCH interventions at community level. According to an FGD with VHTs and KI with the Health Inspector, North Health Sub district, CF was 'facilitating' the VHTs with larger stipends compared to peer organizations in the district. When asked if this would affect their functionality now that the project is coming to an end, some responses recorded included:

> '*but Child Fund found us working as volunteers under the GoU, we will continue'* Odwori Albert, VHT Malomba village, Buyengo Parish

> '*we can't leave mothers and children to die when we are present, full of knowledge'* Oundo Michael, VHT Mumuli village, Buyengo parish

Once the VHTs stipends are institutionalized as discussed by the parliament of Uganda at the beginning of 2020, the functionality and effectiveness of this structure will be strengthened further

3.6.2 Community participation

In Buwumba parish, CF facilitated regular outreaches by the H/C II staff and VHTs. The government of Uganda, according to the Assistant DHO has few resources allocated to outreaches. The midwife at the health center (Buwumba) shared a similar concern. As the CF project was coming to an end, she doubted the ability to find funding to continue the work. But was quick to say the trigger over the last three years could continue to serve as a pull factor, causing even the distant communities to utilize the center based services.

Lack of spousal support

Apio Christine- 40 years participated in the FGD in Buwumba, she freely shared why she gave birth to her 2-year-old at home. 'Whenever I get into labour, my husband is not concerned, he leaves me alone and often goes to drink'. She added that 'I am now used to delivering at home'. Out of her 7 kids, only 1 has been delivered in a health facility.

Despite the FGDs such as in Hasyule and the project reports reporting sensitization on male involvement, findings on the ground still found this a challenge. This was validated by key informant interviews with the district and project staff. As heads of households in charge of resource allocation, men play a critical role in MNCH service utilization because of the cost implications especially in regards to access. '

> *Male engagement is key, in some areas we failed to perform, 100% especially in ante natal seeking behavior because of this'* Semu Okumu, Program Manager BUACOFE

3.6.3 Long term partner – BUACOFE

In Busia district, CF's long-term partner BUACOFE would be expected to incorporate any project gaps into their long term strategy. In fact, in an interview with the Semu

Okumu, the Area Program Manager of BUACOFE, the evaluation team picked up this consciousness as he noted thus

> '*We have picked out some components that will be sustained by BUACOFE e.g. repairs of installed facilities, Mentorship, sourcing of other funders to ensure sustainability'* Semu Okumu

SECTION 4: LEARNINGS AND ACTIONABLE RECOMMENDATIONS

Youth Reproductive Health empowerment is an issue in Busia. The evaluation team encountered teen pregnancies during the data collection, both in the community and those who had come for ANC at the respective health facilities. Border districts come with increased income generating avenues that serve a dual purpose, increasing transactional sex and disinterest in school. As a child focused NGO, this is one other area that CF could potentially consider.

The design of the MNCH project could potentially have generated major learnings to inform policy. Three areas come to mind: a) the intensive community led health service system feedback mechanisms deployed by the project could have investigated the key determinants of health worker sustained performance b) the equally intensive VHT training and mentorship could potentially have also documented key learnings to inform district and national level policy influencing for a such a key community level structure in the government of Uganda health system. C) the maternal and new born death audits, being one of the trailblazer organizations to implement this government policy, Child Fund could have documented key learnings for use by the government as it rolled it out countrywide at the end of the project life. This particular initiative could have been jointly undertaken with World Vision who were equally in the same space.

Low male involvement- as already discussed, this is critical for two reasons: MNCH service access has cost implications that a woman alone may not be able to take charge of. In addition, men have a direct responsibility in child spacing and family planning. When they are not actively involved and challenged, favorable change in the MNCH cannot be sustained at household level. However, targeting this constituency needs more innovative and preferably male peer led interventions. Child Fund would do well to research and craft models that can be piloted and then scaled up.

Under budgeting –there seemed to be gross under estimation of most of the project costs. As stated by one of the implementers, a health center that had a budget allocation of Ugx 9m ended up with a Ugx 30m expenditure. This led to wastage of staff time in budget reviews and fundraising for additional resources. Fortunately, CF has flexible funding frameworks that allow easier movements of resources. It is recommended that CF be more consultative in the budgeting process including involvement of lower cadre staff in the budgeting. The alternative is to undertake price market surveys to try and generate more realistic estimates.

Role of government: Much as the project had done tremendous work to mobilize women to utilize maternal health care services in the various health facilities within the project area, it was clear there are institutional challenges that were beyond the remit of the project. One of this was the staffing challenge. For sustainability, it was wise

that the project didn't intervene in this area directly and yet at the same time; for the future, it is recommended that CF has more proactive interactions with the authorities particularly at MoU level, detailing key deliverables of the government.

SECTION 5: CONCLUSIONS

Overall from both a design and project management perspective, the CF MNCH project was delivered above the development sector expectations. Through the project proposal, the project deliverables and indicators were clearly and logically articulated. The same rigor was transferred to the implementation and reporting as seen from the analytical program reports presented, that identified key challenges and immediate actions taken. The management team of this project demonstrated a high awareness of the need for flexibility to meet the (often) versatile contexts of a typical project implementation in order to enhance achievement of outcomes. For example, tradeoffs were made with other NGOs in the district such as World Vision, adjusting activities to respond to needs on the ground such as with VHTs, fundraising for complementary funding for the Buwumba maternity wing etc. It was clear that the project implementation team was intentional in getting the most impact for the targeted communities.

From an impact perspective, the evaluation team confirmed, by using both qualitative and quantitative data that CF succeeded in ensuring that '*Pregnant and postpartum mothers, and children 0 to 2 years of age achieve good health outcomes'* in Busia district. All the indicators returned a positive improvement apart from the one on immunization that fell back by 12% points (from 99.1% to 79.2%). The evaluation team thinks this could have been a source document issue as ideally the data collectors needed to verify the source of information.

CF funded MNCH project contributed to a district level improvement in the quality of MNCH services. This, according to the assistant DHO moved the rating of the district on the national league table- an annual assessment of all the districts of Uganda by the ministry of health.

CF was rated highly by the district and sub county officials, they were known by name and the evaluation team did not pick up any negative nuances about the organization at all. As an NGO works to complement and within the framework of a local government, good working relationships are a huge bonus in delivering the organization's mission. Already, because of this relationship, innovative programming and the long-term nature of CF's strategy, it would be recommended that CF moves a step further to contribute to improving overall policy and practice in the key sectors of their strategic focus through more active influencing initiatives.

ANNEXES

Annex 1: Questionnaire for Caregivers of Children aged 0-2 years

Note to data collector:

Confirm the category of the respondent first. The key determinant is the age of the child. If child is less than 2 years then interview section 1&2 (MNCH), if above 3 years then interview section 1& 3 (ECD).

Caregiver refers to mother, father or guardian

SECTION 1. HH Information

A	**Interviewee basic information**		
1.	Are you the head of household?	1: YES 2: NO	
2.	How old are you?	1= less than 15 years 3= 51 years and above	2= 15 – 50 years
3.	How long have you been living continuously in present residence?	1 = less than 1 year 3 = 4-6 years 5 = More than 10 years	2 = 1-3 years 4 = 7-10 years
4.	What was the highest level of school you attended?	1 = No education 3 = Secondary school	2 = Primary school 4 = Higher education
5.	What is your occupation?	1 = Housewife 3 = Teacher, civil servant, manager 5 = Doctor, nurse, health worker	2 = Farmer, fishermen, stockbreeder 4 = Service, sales 6 = Other_____
6.	What is your religion?	1 = None 3 = Christian: Church of Uganda (Anglican) 5 = Muslim 7 = Other	2 = Christian: Roman Catholic 4 = Christian: Others 6 = Traditional beliefs
7.	What is your current marital status?	1 = Married or living together 2 = Divorced or separated 3 = Widowed 4 = Never-married and never lived together	
8.	Does your family own a house?		1: YES 2: NO
9.	Does your family own any agricultural or non-agricultural land?		1: YES 2: NO
10.	Does your family own any livestock, herds, other farm animals, or poultry?		1: YES 2: NO

SECTION 2. Maternal and New born Health

B	Pregnancy & Delivery Experience		
11.	How old were you when your first child was born?	1= less than 15 years 3= 51 years and above	2= 15 – 50 years
12.	When was your most recent delivery of a child?	1 = 2020 3 = 2018 5 = 2016 or earlier years	2 = 2019 4 = 2017
13.	During the last pregnancy, how many times did you receive antenatal care? ***[IF one or more time: GO TO 15]***	# of times: 1 # of times: 3 # of times: None	# of times: 2 # of times: 4 88: DON'T KNOW
14.	If 0 time, why did you not receive antenatal care during the last pregnancy?	1 = I didn't have information about antenatal care at health facility 2 = I didn't have a transport to the health facility 3= Facility was too far 4 = I thought services are poor at facility 5 = I thought ANC at the facility is not affordable, financially 6 = I didn't think it was necessary 7 = Family members didn't think it was necessary 8= Others_____	
15.	During the last pregnancy, did you take any medicine (e.g. Fansidar) for malaria prevention? *(if answer is no skip 16/go to 17)*	1: YES	2: NO
16.	How many times did you take any medicine (e.g. Fansidar) during the last pregnancy?	# of times: 1 # of times: 3 # of times: None	# of times: 2 88: DON'T KNOW
17.	Where did you give birth to your baby during the latest delivery? ***[IF 3 and 4: GO TO 19]***	1 = Respondent's home 3 = Government Hospital 5 = Other _____ (Specify)	2 = Other home 4 = Government Health Center
18.	If not facility, what was the main reason you chose to deliver at the given place?	1 = I didn't have a transport to the health facility 2 = Facility was too far 3 = I thought services are poor at facility 4 = I thought delivering at the facility is not affordable, financially 5 = I didn't think it was necessary 6 = Family members didn't think it was necessary	

		7= Others_____ (Specify)	
19.	Who made the decision about your <u>birth place</u> at the last delivery?	1 = Respondent 2 = Husband/partner 3 = Respondent and husband/partner jointly 4 = Parent-in-law and/or parent 5 = Others_____ (Specify)	
20.	During the <u>first 7 days after the last delivery</u>, did community health worker visit your home? ***[IF NO: GO TO <u>26)</u>***		1: YES 2: NO
21.	Did the community health worker (VHT) examine the umbilical cord?		1: YES 2: NO
22.	Did the community health worker (VHT) measure your baby's temperature?		1: YES 2: NO
23.	Did the community health worker (VHT) counsel you on danger signs for newborns?		1: YES 2: NO
24.	Did the community health worker (VHT) counsel you on breastfeeding?		1: YES 2: NO
25.	Did the community health worker (VHT) observe your baby breastfeeding?		1: YES 2: NO
26.	In your opinion, what are some serious health problems that can occur <u>during pregnancy</u> that could endanger the life of a pregnant woman? Ask the respondent to name the problems. DON'T SHOW THE ANSWER **MULTIPLE CHOICES POSSIBLE**	1= Bleeding 3 = Blurred vision 5 = Swollen hands/face 7 = Loss of consciousness 9 = Severe weakness 11 = Reduced fetal movement 13 = Other_____ (Specify) 15 = Don't know	2 = Severe headache 4 = Convulsions 6 = High fever 8 = Difficulty breathing 10 = Severe abdominal pain 12 = Water breaks without labor 14 = None
27.	In your opinion, what are some serious health problems that can occur <u>during labor and childbirth</u> that could endanger the life of a pregnant woman? Ask the respondent to name the problems. DON'T SHOW THE ANSWER **MULTIPLE CHOICES POSSIBLE**	1= Severe bleeding 3 = Convulsions 5 = Loss of consciousness 7 = Placenta not delivered 30 minutes after <u>baby</u> 9 = None	2 = Severe headache 4 = High fever 6 = Labor lasting over 12 hours 8 = Other_____ (Specify) 10 = Don't know
28.	In your opinion, what are some serious health problems that can occur <u>during the first 7 days after</u>	1= Severe bleeding 3 = Blurred vision 5 = Swollen hands/face	2 = Severe headache 4 = Convulsions 6 = High fever

	birth that could endanger the life of the mother? Please name the problems. DON'T SHOW THE ANSWER **MULTIPLE CHOICES POSSIBLE**	7 = Smelling vaginal discharge 9 = Difficulty breathing 11 = Other_____(Specify) 13 = Don' know	8 = Loss of consciousness 10 = Severe weakness 12 = None
C	**Newborn & Child, Family Health Care**		
29.	In your opinion, what are some serious health problems that can endanger the life of a new born baby? Please name the problems. DON'T SHOW THE ANSWER **MULTIPLE CHOICES POSSIBLE**	1= Feel hot / Fever 3 = Convulsion 5 = Yellow eyes or body 7 = Looks weak / only moves if stimulated 9= None 11= Don' know	2 = Refused to breastfeed 4 = Difficulty in breathing 6 = Has pus blisters on the skin 8 = Umbilicus red / discharging pus 10= Other_____ (Specify)
30.	How long after birth should a mother initiate a baby on the breastfeeding?		1 = Within one hour 2 = Within one day 3 = After one day 4 = DON'T KNOW 5 = Other_____ (Specify)
31.	For how long did you exclusively breastfeed your baby?		……months
32.	At what age did you initiate extra feeds to your child? (solid and liquid food)		……months
33.	For how long did you breastfeed your child?		……months
34.	When your children are sick, families can treat at home with the help of VHT. However, with some danger signs you SHOULD immediately refer you children. In which situation, you should refer your children immediately? DON'T SHOW THE ANSWER **MULTIPLE CHOICES POSSIBLE**	1 = A child with convulsion 2 = A child vomits everything 3 = A child with chest in drawing 4 = A child who refuse to eat 5 = A child who is very weak 6= A child who has difficulties in breathing 7 = DON'T KNOW 8 = Other_____ (Specify)	
35.	When MUST someone wash hands? DON'T SHOW THE ANSWER	1= Before eating 3 = Before food preparation 5 = Before feeding a child	2 = After defecation 4 = After cleaning a child's buttocks, after defecation

	MULTIPLE CHOICES POSSIBLE	6 = DON'T KNOW	7 = Other_____ (Specify)
36.	What should be done if a child is to be healthy and grow well? DON'T SHOW THE ANSWER **MULTIPLE CHOICES POSSIBLE**	1 = Feed well 3 = Sleep under ITN 5 = Proper hygiene and sanitation	2 = Be immunized 4 = Seek early treatment when sick 6 = Safe and protective environment
37.	How many <u>immunization visits</u> did you attend with <u>your child of 12-23 months</u>		# of times: …… 88: DON'T KNOW
38.	What is the source of immunization information? If seen take a picture of the immunization card if seen	1= mother's history 2= immunization record(immunization card/book/project card)	
D	**Health Facility & Health care information**		
39.	How long does it take from your home to the nearest health facility on foot?	1 = 30 minutes or less on foot 3 = 2 hours on foot 5 = More than 4 hours on foot	2 = 1 hour on foot 4 = 3 hours on foot
40.	What are your sources of health care information / education in your community? DON'T SHOW THE ANSWER **MULTIPLE CHOICES POSSIBLE**	1= newspaper/radio 2= relevant events (i.e. immunization day) 3 = materials from government/NGO (brochures, posters) 4= health workers from the facility(VHT, doctors, nurses) 5= community members(family, friends, neighbors, religious leaders etc)	
E	**Perceptions on Maternal care service**		
I would like to know your opinions on following questions. There is no right or wrong answer to any of these questions. We are only interested in hearing your opinion.			
41.	Would you consider going to health facilities to receive antenatal care <u>during your next pregnancy</u>?		1 = YES 2 = NO 3 = NOT SURE
42.	Would you consider going to health facilities to deliver your next child?		1 = YES 2 = NO 3 = NOT SURE
43.	Do you think health workers, at the nearest delivery facility, know what kind of care a woman needs during pregnancy, delivery, and immediately after delivery?		1 = YES 2 = NO 3 = NOT SURE
44.	Do you think traditional birth attendants know what kind of care a woman needs during pregnancy, delivery, and immediately after deliver?		1 = YES 2 = NO 3 = NOT SURE
45.	Do you think health workers, at the nearest delivery facility, treat women with respect?		1 = YES 2 = NO 3 = NOT SURE

46.	Do you think traditional birth attendants treat women with respect?	1 = YES 2 = NO 3 = NOT SURE
47.	Do you think health workers, at the nearest delivery facility, know what to do in case of complications?	1 = YES 2 = NO 3 = NOT SURE
48.	Do you think traditional birth attendants know what to do in case of complications?	1 = YES 2 = NO 3 = NOT SURE
49.	Do you think the nearest delivery facility has adequate supply of drugs?	1 = YES 2 = NO 3 = NOT SURE
50.	Do you think the nearest delivery facility has adequate number of health personnel?	1 = YES 2 = NO 3 = NOT SURE
51.	Do you think the cost of delivery at the nearest delivery health facility is free/affordable?	1 = YES 2 = NO 3 = NOT SURE

Annex 2: VHT Interview Guide

Name of VHT……
Village……
Sub county ……
Contact……

- What is your role as a VHT in the CF funded MNCH project?/ How have you participated in the design, implementation and monitoring of this project?
- How were you using the IEC materials developed by CF? how helpful were they? Do you still have any copies of the materials?
- Please explain the capacity building and mentorship offered by CF. How did it help you do your work? Please give clear examples
- What difference did the tracking of mothers for MNCH services in the community make in increasing service utilization? How many mothers could you visit in a month? How different was this from years before the CF project?
- What according to you would be the greatest achievement of this CF project?

Annex 3: Checklist for Health Unit Management Committee (HUMC)

HEALTH FACILITY ASSESSMENT

Name of facility	
Name of Parish	
Name of Sub county	
Level of facility	HC II / HC III
Type of facility	GOVERNMENT / PRIVATE-NOT-FOR-PROFIT
Name of interviewer	
Date of interview (dd/mm/yyyy)	

GENERAL INFORMATION

FIND THE MANAGER, THE PERSON IN-CHARGE OF THE FACILITY, OR MOST SENIOR HEALTH WORKER WHO IS PRESENT AT THE FACILITY. READ THE FOLLOWING GREETING:

Good day! My name is _____. We are here on behalf of the Uganda Bureau of Statistics conducting a survey of health facilities to assist the government in knowing more about health services in Uganda.

Now I will read a statement explaining the study.

Your facility was selected to participate in this study. We will be asking you questions about general information on your health facility. Information about your facility may be used by the MOH, organizations supporting services in your facility, and researchers, for planning service improvement or for conducting further studies of health services.

Neither your name nor that of any other health worker respondents participating in this study will be included in the dataset or in any report; however, there is a small chance that any of these respondents may be identified later. Still, we are asking for your help to ensure that the information we collect is accurate.

If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate if you introduce us to that person to help us collect that information.

At this point, do you have any questions about the study? Do I have your agreement to proceed?

Name of interviewee : _____

Position of interviewee : _____

INTERVIEWER'S SIGNATURE INDICATING CONSENT OBTAINED : _____

Category	Standard	Evaluation	
		Check	Remarks
Composition	**Does committee (6) consist of persons drawn from the followings:** - Chairperson: A prominent educated public figure of high integrity and not holding any political position from the sub-county or division council to be nominated by sub-county local council - Secretary: In charge of Health Unit - 3 Members: One educated representative of high integrity from each parish chosen by the parish council and taking into consideration gender responsiveness - Member: A center teacher of the zone where HC3 is located		
Roles & Responsibilities	**Does HUMC members understand their Roles & Responsibilities?** - to supervise management of HC2/3 finances - to approve the annual budgets - to ensure that annual work plans are drawn up reflecting priority needs - to monitor the performance of the approve budget		
Function	**Does HUMC have meet regularly to discuss facilities business?** - How many times in the 3 quarters ____ (with documented minutes)		
Capacity building	**Has the HUMC ever been trained?** -indicate the trainings which have ever received		
Community participation	How has the HUMC involved the community in the planning and management of MNCH services in this area		
Quality of services	What initiatives has the HUMC taken to increase utilization of MNCH services among women in this center?		

Annex 4: KI guide for the MCHN and ECD Project Implementers/managers

A. Background Information

Name

Position

Role in the project

Gender

Questions

Relevance

1. Why did Child Fund have to implement these projects in Busia in particular?
2. How does CF link with the district respective education and health departments, how do these projects relate to priorities of the district?

Efficiency and effectiveness

3. Value for money- do you think the project could have been delivered more cheaply? Why?
4. What are the key practical considerations specific to this project (MCHN or ECD) employed to deliver value for money?
5. How has the ECD or MCHN project ensured timeliness in the delivery of outputs? Please give specific examples
6. What is the structure of the ECD and MCHN project? How do the two projects relate?

Impact

4. As an implementer, which project achievements you are most proud of?
5. How did this change the lives of the target group? Be as specific as possible
6. Are there families that directly benefited from both projects? How differently were they impacted compared to the rest? Give 3 examples of such. (***evaluation team to go document 2-3 of such families***)

Sustainability

7. What elements of the intervention package were useful for scale up?
    - Name the elements
    - For each of the issues mentioned, ask why they say so
    - What aspects need modifications?
    - What are the suggestions for the modifications?
    - What do you do think should have been done differently? Why?
    - What recommendations can you give for future projects?

Others

8. What was the most innovative aspects of the ECD or MCHN project
9. What key lessons have you learnt in the course of implementing the ECD or MNCH Interventions in the project areas?
10. What are the greatest challenges that you faced as project (implementers, Managers) when implementing the project in project area? Why do you say so?
11. How did you overcome the challenges you faced?

Annex 5: Focus Group Interview Guideline for Facilitators (Women)

Instruction

Total number of participants for each focus group should be between 5-6 participants given the COVID19 Standard Operating Procedures. Only women will be interviewed

Moderator:

Hello, everyone! My name is _____. And also _____ will be here to observe and record our conversation. On behalf of ChildFund, I would like to thank you for your participation today. Your opinions will serve as a valuable source in the development of maternal and child health education messages and informative materials on healthy motherhood and child birth for women like you.

Please speak freely and honestly about each topic I present in a minute. The discussion will last less than 2 hours. And remember that there is no right or wrong answer. Please feel free to talk about your thoughts and opinions on health care services, home-visiting services (community health worker's services) and pregnancy-related topics in general.

Opening Questions

1. What do you know about the Child Fund/BUCODEF funded projects in this location? - wh at kind of projects and who do they target?
2. Do you know some of the BUCODEF staff members? How frequently do they interface wi th you?

ECD

1. Does every child in the community here attend ECD centers?
2. For those with children attending ECD, what difference have you seen in your child at tending an ECD center. Please provide clear examples. Can you compare with the ki ds who don't attend?
3. As a home care giver, what have you learnt from this project about child development / child care that you did not know before?

MCHN project

1. What difference has BUCODEF project made in MCHN services in this location? Wha t was the situation before their intervention? How is it now?
2. What is your experience of the MCHN services offered at the health centers? Are you happy about them?
3. What more could be done to improve the state of MCHN in this locality?
4. If BUCODEF had to come back and implement a similar project, what should they do differently for a) MCHN, b) ECD

Apply the Most significant change technique tool (annex 6)

Annex 6: MOST SIGNIFICANT CHANGE TOOL

Background

We have been contracted by Child Fund to evaluate the two projects ECD and the MCHN (data collector to specify which is relevant to the respondent). We would like to capture stories of significant change that may have resulted from this project to enable us to celebrate the successes together as well as account to our donors/friends who supported to fund this project

Contact details

Name of storyteller (*but taking your name is not mandatory if you don't wish*)

Name of person recording story

Location

Date of recording

Consent

We may like to use your stories for reporting to our funders, or publishing on internet/website for example

Do you, (the storyteller):

• want to have your name on the story (*tick one*) Yes ☐No ☐

• Consent to us using your story for publication (*tick one*) Yes ☐ No ☐

1. Tell me how you (the storyteller) first became involved with the Child Fund MCHN/ECD project and what your current involvement is:

---

2. From your point of view, describe a story that summarises the most significant change to you as an individual or your community or your family that has resulted from this MCHN or ECD project

---

3. Why was this story significant for you?

---

4. How, (if at all) has the work of Child Fund/BUACOFE contributed to this?

Annex 7: Perception Score by Women

Perceptions on maternal health care		YES	NO	NOT SURE
1.	Would you consider going to health facilities to receive antenatal care during your next pregnancy?	99.2%	0.5%	0.3%
2.	Would you consider going to health facilities to deliver your next child?	98.7%	1.3%	
3.	Do you think health workers, at the nearest delivery facility, know what kind of care a woman needs during pregnancy, delivery, and immediately after delivery?	96.04 %	1.85%	2.11%
4.	Do you think traditional birth attendants know what kind of care a woman needs during pregnancy, delivery, and immediately after deliver?	30.9%	31.7%	37.4%
5.	Do you think health workers, at the nearest delivery facility, treat women with respect?	92.3%	5.8%	1.9%
6.	Do you think traditional birth attendants treat women with respect?	35.1%	26.6%	38.3%
7.	Do you think health workers, at the nearest delivery facility, know what to do in case of complications?	97.1%	1.8%	1.1%
8.	Do you think traditional birth attendants know what to do in case of complications?	14.5%	50.9%	34.6%
9.	Do you think the nearest delivery facility has adequate supply of drugs?	46.2%	48.3%	5.5%
10.	Do you think the nearest delivery facility has adequate number of health personnel?	48.6%	46.4%	5.0%
11.	Do you think the cost of delivery at the nearest delivery health facility is free/affordable?	58.5%	38.5%	3.2%

Annex 8: Endline Evaluation MNCH Project Analysis Plan

No.	Indicator	Source	Question	Supplementary	Cut-off criteria
1	% of pregnant women who know at least 4 danger signs during pregnacy	Survey	26		count only the women who answered 4 or more signs.
2	% of pregnant women who know at least 4 dangers signs during delivery		27		count only the women who answered 4 or more signs.
3	% of pregnant women who know at least 4 dangers signs during postpartum		28		count only the women who answered 4 or more signs.
4	% of pregnant women who know at least 4 newborn danger signs		29		count only the women who answered 4 or more signs
5	% of parents aware of at least 4 key child family health care practices		36	30-33: infant feeding 34: when child sick 35: WASH 37: immunization	count only the women who answered 4 or more choices
6	% of pregnant women who attend at least 4 antenatal visits		13	FGD Exploration Q1, 2	count only the women answered 4 or more times
7	% of pregnant women who give birth at health facility		17	survey Q18, Q41-51 FGD Exploration Q1, 2	count only the women answered 3 or 4
8	% of children 12-23 months who are fully immunized		37	Q36, 38	count only the women answered 4 or more visits
9	No. of health facilities with active health unit management committees	Checklist			count only when the committee satisfies all standards below - composition (existence, membership according to policy) (HC 2=5, HC 3=7) - R&R (clearly understand their R&R) - Function (meeting at least once in last six month, minutes available)

Annex 9: Sampling Plan for Survey

BUHEHE Sub-county (57 samples)			DABANI Sub-county (95 samples)			LUMINO Sub-county (76 samples)			MAJANJI Sub-county (76 samples)			MASINYA Sub-county (76 samples)		
Parish	**Village**	**# of sample**	**Parish**	**Village**	**# of sample**	**Parish**	**Village**	**# of sample**	**Parish**	**Village**	**# of sample**	**Parish**	**Village**	**# of sample**
BUHASABA	Buchaki 'A'	2	BUSIA	Bugunduhira 'B'	4	JINJA	Buchwere	3	MAJANJI	Bulwande	3	BUMUNJI	Budibya	3
	Buchaki 'B'	2		Busiwondo"B	2		Budalangi	2		Maduwa 'B'	3		Bulongi	2
	Buhasaba	2		Hawadunga 'East'	2		Butula 'B'	2		Maduwa 'A'	2		Buwalira	6
	Bulamba 'A'	2		Namaubi A	4		Buwerero 'A'	3		Magombe	2		Bwaya	5
	Bulamba 'B'	2		Namaubi B	4		Doma	2		Majanji	4		Hadoda	3
	Dakha	4		Syamutumba East	3		Muluko	2		Namundiri 'A'	2	BUSIKHO	Busikho East	2
	Madibira	2	BUYENGO	Buyengo 'A'	2		Syamaledde 'A'	4		Namundiri 'B'	3		Busikho West	3
	Mukwanya	3		Buyengo 'B'	2	LUMINO	Bulangi	3	NAGABITA	Buhenye A	3		Buyimini West	3
BUHEHE	Budibya	2		Lugega	4		Bumala	3		Buhenye 'B'	2		Buyimni East	2
	Buwolia 'A'	2		Malomba	4		Lumino I	5		Butula 'A'	4		Buyiye East	3
	Buwolia 'B'	3		Mumuli	2		Lumino II	3		Bwakama A	2		Buyiye West	2
	Kateruhana East	3		Yaala	5		Lusisira	2		Bwakama 'B'	3		Siduhumi	4
	Kateruhana West	2	BUWUMBA	Bukanga 'N'	2		Nandwa 'A'	3		Musuma	3	BUTOTE	Buduma	2
	Musohe	3		Bukanga 'S'	2	HASYULE	Bugati	3		Nahabanjjo	2		Buhasoho	2
	Nangodo 'A'	2		Bukemo	3		Bukani	4	DADIRA	Bubala 'B'	3		Bujabi North	4
	Nangodo 'B'	2		Bumakwa 'A'	3		Hasyule 'A'	4		Buyore	5		Bujabi South	2
BULWENGE	Bujwanga	3		Buwawo	3		Nebolola 'A'	4		Dadira	4		Butote	4
	Buyuha	3		Buwumba	4		Nebolola 'B'	4		Mororo	4		Buyuya	5
	Gunda	3		Buyaya	2	BUDIMO	Budibya	2		Sitengo	3	MASINYA	Buhumwa	5
	Mahola	2	DABANI	Buchiwedo 'A'	4		Budimo 'A'	3	JJUNGE	Dikho	4		Bulecha	4
	Maanga	2		Busabale 'S'	3		Budimo 'B'	2		Lumidi	4		Bunyukhe	4
	Muganiro	4		Buwuma 'A'	2		Budimo 'C'	2		Rugega	3		Busamba	2
	Sibona	2		Buwuma 'B'	3		Budimo 'D'	3		Syakula	3		Gulamubiri	4
				Dabani 'A'	3		Bukobe	3		Syangu	5			
				Dabani B	2		Namusenda	4		Sitengo	3			
				Dabani West	2									
			NANGWE	Busumba 'B'	3									
				Mundaa A	2									
				Mundaa B	3									
				Nandere	2									
				Nangwe A	2									
				Nangwe B	3									
				Nangwe North	2									
				Nangwe South	2									

Annex 10: Key Informant Interviewees Interviewed

Number	Structure	Name	Location	Sex	Contact
1.	VHT	Apio Joyce	Bunyide village, Buhehe sub county	F	0780327419
2.	VHT	Nekesa Margaret	Nangwe B	F	
3.	VHT	Ouma Jairus	Lugega	M	
4.	VHT	Ajambo Juliet	Buyengo B	M	
5.	VHT	Oliwa George	Nangwe North	M	
6.	VHT	Nanjuko Annette	Musumba A	F	
7.	Midwife	Nabwire Rosette	Hasyule Health Centre 11	F	0752716116
8.	CDF	Okotch Edwin	Buyengo community	M	0787178447
9.	Parents Exec Committee member	Sunday Phanisce	Buyengo community	F	0787772809
10.	Health workers	Alepus Dinah	Buwumba Health center II	F	0775707484
11.	Health workers	Isiko Joseph	Buwumba Health center II	M	0779834820
12.	Chairperson ECD center committee	Kabembe Boniface	Buwumba ECD	M	0779176650
13.	Head caregiver	Doreen	Buwumba ECD	F	0771135056
14.	Parents representative	Were Stephen	Buwumba ECD	M	0784487349
15.	Head teacher	Erukana Ronald	Buwumba primary school	M	0781558255
16.	Ag Community Development Officer	Abanjo Reste	Dabani Sub county	F	
17.	Health inspector, North health sub district	Nekesa Jackline	Busia district	F	
18.	Nursing officer	Oupepe Charles	Bumunju Health center	M	
19.	Assistant DHO Maternal Child Health	Sr. Berna Nanyama	Busia district	F	0782823379
20.	District bio-statistician	Carolyn Balwanakyi	Busia district	F	0752445533
21.	Community Development Officer	Nekesa Jackie	Masinya & Masafu Sub counties	F	0772322841
22.	District ECD Focal Person	Patrick Barasa	Busia	M	0773815696
23.	Community Development Officer	Wasike George	Buhehe Sub county	M	0773533639
24.	LC 111 Chairman	Wanyama Charles Hasibeni	Buhehe Sub county	M	0782584673
25.	ECD Caregiver	Hasifa Salima	Bulwande ECD Centre, Majanji S/c	F	0772011842
26.	ECD Caregiver	Auma Grace	Bulwani ECD Centre, Buhehe S/c	F	0777463826

Annex 11: Focus Group Discussion

Number	Name	Structure	Location	Sex	Contact
1	Nerima Doreen	Mother of children <5 years	Buwumba Health Centre	F	0771135056
2	Anyokot Margaret	Mother of children <5 years	Buwumba Health Centre	F	0786274944
3	Mukwana Elizabeth	Mother of children <5 years	Buwumba Health Centre	F	0773954794
4	Nassirumbi Betty	Mother of children <5 years	Buwumba Health Centre	F	
5	Akware Angel	Mother of children <5 years	Buwumba Health Centre	F	0785765575
6	Apio Christine	Mother of children <5 years	Buwumba Health Centre	F	
7	Lyaka Stella	Mother of children <5 years	Buwumba Health Centre	F	0783089185
8	Sanya Catherine	Mother of children <5 years	Buwumba Health Centre	F	0773916516
9	Taaka Catherine	Mother of children <5 years	Buwumba Health Centre	F	
10	Mukula Jacklyne	Mother of children <5 years	Buwumba Health Centre	F	
11	Wasike Peter	ECD Caregivers	Sibiyirise ECD Centre	M	0788486903
12	Hayoko Judith	ECD Caregivers	Sibiyirise ECD Centre	F	0772630517
13	Chabadira Risper	ECD Caregivers	Sibiyirise ECD Centre	F	0785568507
14	Monica Wafula	ECD Caregivers	Sibiyirise ECD Centre	F	0770820279
15	Jenipher A. Ouma	ECD Caregivers	Sibiyirise ECD Centre	F	0770782154
16	Mugeni Lucy Wandera	ECD Caregivers	Dakha ECD Centre	F	0776749935
17	Anyango Jane	ECD Caregivers	Dakha ECD Centre	F	0775659375
18	Ajiambo Susan	ECD Caregivers	Dakha ECD Centre	F	0759992406
19	Bwire John Emmanuel	ECD Caregivers	Dakha ECD Centre	M	0774398133
20	Nabwire Caroline	In/Charge	Majanji Health Centre	F	
21	Nyongesa Everline	R/M	Majanji	F	
22	Adeya Godfrey	Parish Chief	Majanji Sub county	M	
23	Hasifa Alima	ECD Caregiver	Bulwande ECD Centre	F	
24	Tilla Ojones	ECD Chairman	Bulwande ECD Centre	M	