

Mid-term evaluation of the Maternal and Newborn Health Thematic Fund

Phase III 2018-2022

Uganda



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MID-TERM EVALUATION OF THE MATERNAL AND NEWBORN HEALTH THEMATIC FUND PHASE III, 2018-2022

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FOREWORD

Since 2008, the MHTF has served as the UNFPA flagship programme on maternal and newborn health. Now in Phase III, the MHTF has widened its scope to contribute to the broader sexual and reproductive health and rights agenda impelled by the International Conference on Population and Development's (ICPD) Programme of Action. Joining the momentum built up around the necessity of a greater focus on the newborn period along the continuum of care, and recognizing the indivisible interconnections between maternal and neonatal health (MNH), it changed its name to the Maternal and Newborn Health Thematic Fund in 2018. Its goal is to enable every woman, adolescent girl and newborn to have equitable and accountable access to quality sexual, reproductive, maternal and newborn health and rights by strengthening health systems in countries with a high burden of maternal morbidity and mortality, thus contributing to the global target of having fewer than 70 maternal deaths per 100,000 live births by 2030 (Sustainable Development Goal 3, Target 1).

The mid-term evaluation of the MHTF (Phase III) was conducted as an independent assessment of the performance of the MHTF in providing catalytic support through country-owned and -driven interventions in order to improve maternal and newborn health and rights in 32 high-mortality countries. The evaluation covers the period from 2018 to 2021 and provides learning to feed into the implementation of the MHTF in its current phase. It also informs the reflection on the strategic directions and operating model for the MHTF post 2022.

The evaluation highlights the significant and tangible contributions of the MHTF to country health systems and shows how the MHTF model (a combination of seed funding, links to established global partnerships, and technical support) enables programme countries to access guidance and support to upgrade relevant national approaches in order to meet global standards. In fact, the MHTF brings value across a significant range of technical areas and delivers considerable thrust with a limited package of resources, opening, in countries, specific entry points for health systems strengthening and for the integration of SRHR-MNH services. With the MHTF, UNFPA is a credible partner, taking the lead in midwifery, and is consistently valued for its responsiveness and strategic investments as well as for its knowledge products and technical guidance in maternal, newborn and adolescent health.

However, the MHTF faces a number of challenges that have started to constrain its impact, or will do so in the future. The evaluation points, in particular, at the need to engage with communities to address barriers to access, to overcome delays, to improve accountability and to better ground MHTF investments with affected populations. To fully exercise its catalytic effect, the evaluation also shows how important it is for the MHTF to further engage national leadership for MNH in order to target the resource mobilization needed to take technical advances to scale. This is key to support greater institutionalization of the MHTF systems strengthening investments.

I am confident that the lessons learned and the recommendations highlighted by this mid-term evaluation will help to further enhance the contribution of UNFPA and the MHTF to maternal and newborn health. The evaluation results are also particularly relevant as UNFPA channels its efforts to help health systems recover from the COVID-19 pandemic so that progress continues to be made in advancing sustainable development and promoting the health, rights and well-being of mothers and newborns to ensure that no one is left behind.

Marco Segone

Director

UNFPA Evaluation Office

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ABBREVIATIONS AND ACRONYMS

ADH	Adolescent health
ANC	Antenatal care
ASRHR	Adolescent sexual and reproductive health and rights
ASRO	Arab States regional office
BEmONC	Basic emergency obstetrics and newborn care
CEmONC	Comprehensive emergency obstetric and newborn care
CO	Country office
COVID-19	2019 novel coronavirus/Corona virus disease/SARS-CoV-2
CP	UNFPA country programme
CQI	Continuous quality improvement
DHO	District health office
EASRO	East and Southern Africa regional office
EmONC	Emergency obstetric and newborn care
EPMM	Ending Preventable Maternal Mortality initiative
FCDO	Foreign, Commonwealth and Development Office (UK)
FGM	Female genital mutilation
GBV	Gender-based violence
GDP	Gross domestic product
GIS	Geographic Information System
GoU	Government of Uganda
H6	A group comprising six United Nations health agencies (WHO, UNAIDS UNFPA, UNICEF, UN Women, World Bank)
HC	Health centre
HMIS	Health management information system
HQ	Headquarters
HSDP	Health sector development plan
HUMC	Health unit management committee
ICM	International Confederation of Midwives
IDEOF	International Day to Eliminate Obstetric Fistula
IDM	International Day of the Midwife
IEC	Information, education and communication
IP	Implementing partner
IPC	Infection prevention and control
IUD	Intra uterine device
MCH	Maternal and child health
MDR	Maternal death review
MDSR	Maternal death surveillance and response
MHTF	Maternal and Newborn Health Thematic Fund
MISP	Minimum Initial Service Package (reproductive health)
MMR	Maternal mortality ratio
MNCH	Maternal, newborn and child health
MNH	Maternal and newborn health
MoES	Ministry of Education and Sports
MoH	Ministry of Health
MPDSR	Maternal and perinatal death surveillance and response

MSU	Marie Stopes Uganda
MTI	Medical Teams International
NGO	Non-governmental organization
NICU	Neonatal intensive care unit
NMAU	National Midwives Association of Uganda
NRH	National referral hospital
OB/Gyn	Obstetrics/gynaecology
PAC	Post-abortion care
PHC	Primary health care
PMTCT	Preventing mother-to-child transmission of HIV
PPE	Personal protective equipment
PPFP	Post-partum family planning
PPH	Post-partum haemorrhage
QI	Quality improvement
RICE	Rural Initiative for Community Empowerment
RMNCAH	Reproductive, maternal newborn, child and adolescent health
RRH	Regional referral hospital
SCCTP	Structured and Collaborative Clinical Training Programme
SDG	Sustainable Development Goal
SGBV	Sexual and gender-based violence
SRH	Sexual and reproductive health
SRHR	Sexual and reproductive health and rights
SRMNCAH	Sexual, reproductive, maternal, newborn, child and adolescent health
STI	Sexually transmitted infection
Terrewode	“Association for the Rehabilitation and Re-orientation of Women for Development”
The Global Fund	The Global Fund to fight AIDS, Tuberculosis and Malaria
ToT	Training of trainers
TWG	Technical working group
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UNMC	Uganda Nurse and Midwives Council
UNMEB	Uganda Nurse and Midwives Medical Examination Board
UPMA	Uganda Private Midwives Association
USAID	United States Agency for International Development
VHT	Village health team
WHO	World Health Organization

GLOSSARY OF TERMS

Term	Definition	Source
Child marriage	Child marriage is any formal marriage or informal union where one or both of the parties are under 18 years of age. Each year, 12 million girls across the world are married before the age of 18. Complications in pregnancy and childbirth are the leading cause of death in girls aged 15-19 globally.	https://www.girlsnotbrides.org/about-child-marriage/ https://www.girlsnotbrides.org/themes/health/
EmONC: Emergency obstetric and neonatal care	<p>A standard of care to manage obstetric complications. EmONC designated facilities must have skilled attendants covering 24 hours a day, seven days a week, assisted by trained support staff.</p> <p>Basic EmONC (BEmONC) includes seven capacities: (1) parenteral treatment of infection (antibiotics); (2) parenteral treatment of post-partum haemorrhage (uterotonic drugs like oxytocin); (3) parenteral treatment of pre-eclampsia/eclampsia (anticonvulsants like magnesium sulphate); (4) manual removal of the placenta; (5) removal of retained products following miscarriage or abortion; (6) assisted vaginal delivery, preferably with vacuum extractor; and (7) basic neonatal resuscitation care.</p> <p>Comprehensive EmONC (CEmONC) includes these seven capacities plus the provision to conduct a caesarean section/surgery and to administer safe blood transfusions.</p>	https://www.unfpa.org/feature-d-publication/implementation-manual-developing-national-network-maternity-units
Integrated MNH and SRHR	This term refers to the integration of maternal and newborn health (MNH) and sexual and reproductive health and rights (SRHR) information and services. Note that the evaluation will not utilise the acronym for reproductive, maternal, newborn, child and adolescent health, as child health is not part of the scope of the evaluation. The MHTF encompasses focus areas related to MNH and SRHR interventions, including family planning, preventing mother-to-child transmission of HIV, prevention of HIV/sexually transmitted infections (STIs), and cervical cancer prevention and screening. A focus on adolescents cuts across all MHTF interventions related to MNH and SRHR.	https://www.unfpa.org/sites/default/files/pub-pdf/UNFPA-MHTF-WEB.pdf
Maternal and Newborn health (MNH)	Maternal health refers to the health of women during pregnancy, childbirth, and the postnatal period (42 days following birth). Newborn health focuses on improving care around the time of birth and in the first four weeks of life.	<p>https://www.who.int/health-topics/newborn-health#tab=tab_1</p> <p>https://www.who.int/health-topics/maternal-health#tab=tab_1</p> <p>Accessed from World Health Organization accessed February 27, 2021</p>

Term	Definition	Source
Maternal and perinatal death surveillance and response (MPDSR)	MPDSR is a continuous cycle of identification, notification and review of maternal deaths with recommendations made to improve care. The full cycle also includes follow-up of actions taken to improve quality of care and prevent future deaths.	https://www.who.int/maternal_child_adolescent/epidemiology/maternal-death-surveillance/en/
Maternal mortality ratio	The number of maternal deaths during a given period per 100,000 live births during the same period. The global maternal mortality target (to reduce maternal deaths to at least as low as 70 per 100,000 live births) was agreed in 2015 in a consensus paper on Ending Preventable Maternal Mortality (EPMM) and adopted as the Sustainable Development Goal (SDG) target (SDG indicator 3.1.1). Maternal mortality is measured less frequently than other indicators (every 3 to 5 years) and evidence would be strengthened where country civil registries and vital statistics systems were strengthened. There is a tendency in many countries to underreport maternal deaths.	Health statistics and information systems: Maternal Mortality Ratio World Health Organization accessed 25 Feb 2021.
Newborns/ neonates	A newborn or neonate is a baby in its first 28 days of life. About 75 per cent of neonatal deaths occur in the first seven days of life and a third of these on the day of birth. Neonatal deaths are primarily caused by birth injuries and asphyxia, preterm birth, post-partum infections and birth defects.	https://www.who.int/news-room/fact-sheets/detail/newborns-reducing-mortality Ending Preventable Newborn Deaths and Stillbirths, 2020-2025, UNICEF, 2020
Obstetric fistula	Obstetric fistula is a serious childbirth injury. It is a hole that has opened between the birth canal and bladder and/or rectum and is caused by prolonged, obstructed labour without access to timely, high-quality medical treatment. It leaves women leaking urine and/or faeces and can lead to chronic medical problems, social isolation and deepening poverty.	https://www.unfpa.org/obstetric-fistula
Perinatal death	A death that occurs between 28 weeks of completed gestation and the first seven days of life.	
Sexual and gender-based violence (SGBV)	SGBV refers to harmful acts directed at an individual based on their gender. It is rooted in gender inequality, patriarchal norms and harmful practices. SGBV is a violation of human rights and a life-threatening health and protection issue. It is estimated that one in three women will experience sexual or physical violence in their lifetime. During displacement and times of crisis, the threat of SGBV significantly increases for women and girls.	https://www.unhcr.org/uk/gender-based-violence.html

Term	Definition	Source
SRHR	A comprehensive range of services to enable every person to achieve sexual health and well-being. Services include contraceptive services; maternal and newborn care; prevention and control of STIs, including HIV; comprehensive sexuality education; safe abortion care, including post-abortion care; prevention, detection, and counselling for SGBV; prevention and treatment of infertility and cervical cancer; and counselling and care for sexual health and wellbeing	Guttmacher Lancet Commission on SRHR: https://www.guttmacher.org/guttmacher-lancet-commission/accelerate-progress-executive-summary# This definition was endorsed by WHO and UNFPA: https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(18)30901-2/fulltext
Stillbirth	A baby born with no signs of life at or after 28 weeks of gestation. There are different types of stillbirths. More than half of all stillbirths for example occur during labour and birth. The majority are preventable.	Ending Preventable Newborn Deaths and Stillbirths, 2020-2025, UNICEF, 2020
Young people, youth and adolescents	<p>Child: a person under 18 years of age, as defined by the United Nations.</p> <p>Adolescent: a person aged 10 to 19 years, as defined by the United Nations.</p> <p>Young person: a person between 10 and 24 years old, as defined by WHO.</p> <p>Youth: a person between 15 and 24 years old, as defined by the United Nations. The United Nations uses this age range for statistical purposes but respects national and regional definitions of youth.</p>	UNESCO (2018) <i>International technical guidance on sexuality education: An evidence-informed approach</i>

EXECUTIVE SUMMARY OF THE OVERALL MID-TERM EVALUATION OF THE MHTF PHASE III (2018-2022)

PURPOSE AND SCOPE OF THE EVALUATION

Ending preventable maternal deaths is one of three transformative results of United Nations Population Fund (UNFPA) and includes an emphasis on the integration of sexual and reproductive health and rights (SRHR) with maternal and newborn health (MNH) services. The Maternal and Newborn Health Thematic Fund (MHTF) was first established in 2008 and, now in its third phase, is closely associated with this transformative result. Unfortunately, global progress on maternal and newborn mortality reduction is not on track to meet the 2030 Sustainable Development Goal (SDG) targets and has been further affected by the health, social and economic effects of the global COVID-19 pandemic.

The MHTF delivers technical and financial support in 32 high burden countries to create catalytic and accelerated progress in one or more of four priority technical areas: midwifery, emergency obstetric and newborn care (EmONC), maternal and perinatal death surveillance and response (MPDSR) processes, and the prevention and treatment of fistula and other obstetric morbidities. The MHTF also contributes to the UNFPA presence and leadership of maternal health at the global level.

This evaluation assesses the MHTF progress against its 2018-2022 Business Plan and identifies key lessons and challenges to support its future evolution. In particular, the evaluation considers the extent to which the MHTF has contributed to strengthening health systems, improving quality of care, and advancing equity, human rights and accountability to stakeholders in partner countries. The evaluation also assesses the extent to which the MHTF supports the scaled up integration of SRHR-MNH services, reflecting the well-established and critical role of universal access to quality SRHR services as essential to achieving MNH.

METHODOLOGY

The evaluation identifies the contribution made by UNFPA and applies a theory-based approach in order to analyse the intended results of UNFPA support. It also takes into account the larger health system factors and economic and social determinants affecting MNH. The evaluation team adapted the MHTF theory of change to incorporate all aspects of UNFPA support and developed a series of nine detailed evaluation questions to set out and define the areas of research. Associated with each question, key causal assumptions were tested via indicators using primary and secondary data gathered, analysed and presented by the evaluation team.

Data collection was structured around six country case studies (Benin, Sudan, Uganda, Zambia, Bangladesh and Togo) involving a range of methods and sources including document review, country-focused interviews and group discussions and, where feasible (given COVID-19 legal and public health restrictions), site visits and observation. Data were also collected through key informant interviews with global and regional stakeholders, through a comprehensive review of relevant documents and data sets at the global and regional levels and through an online survey completed by respondents from the MHTF partner countries. The evaluation followed a structured plan for analysis and triangulation of the data to respond to the nine questions.

MAIN FINDINGS

As one of the few United Nations funds and programmes supporting midwifery, with the MHTF, UNFPA has succeeded in raising the profile and standing of midwives at the global and country levels. The UNFPA partnership with the International Confederation of Midwives (ICM) is a key asset that amplifies its credibility with partner governments, supporting the alignment of national policies with international standards. MHTF investments and expertise have led to global policy products and practical benefits supporting midwifery development in countries beyond the MHTF. Professional

development is a long-term process, and the key challenge for the MHTF and its partners remains how to put midwifery policies into action at scale, particularly with limited resources. Furthermore, while UNFPA is ambitious in its aim to eradicate gender disparities, action taken in countries to ensure midwives have a seat at the table to effect policy change is inconsistent. Nonetheless, MNH partners recognize midwifery support as a central pillar of the MHTF and a critical driver of other technical priorities (namely EmONC, fistula and MPDSR) as well as a crucial strategy for effective integration of SRHR and MNH services despite a lack of holistic programming in some contexts.

The MHTF has championed the development and application of the EmONC network model in selected partner countries using an innovative health systems strengthening approach based on consensus building around standards of care, the rationalization of EmONC facility distribution, and routine facility monitoring. The phased approach of the EmONC network offers an objectively verifiable model for elaborating service delivery standards that can be adapted to each country context. Viewed by key informants as rigorous and credible, this methodology – and the MHTF application of it - enables a concrete step forward in EmONC and MNH systems strengthening that creates leadership opportunities in partner countries and opens a pathway to improving quality of care. Two limitations affect the long-term sustainability of the MHTF investments in EmONC. The first is the limited consideration given so far to including the community level as a structured part of care networks. The second is the challenge of sustainability through the institutionalization of the monitoring process associated with quality improvement and without which the benefits of the model will be difficult to maintain. An additional challenge for the MHTF, given the range of countries it supports (including many that do not implement the EmONC network approach), is to balance a flexible and country responsive approach to EmONC support while also ensuring sufficient links to larger health system reform processes.

Sustained MHTF partnership has enabled MPDSR processes to be somewhat embedded across a range of health systems contexts and is valued by country governments and partners. MHTF technical and financial resources enable countries to develop MPDSR strategies, implement national and subnational committee structures and produce periodic reports. The MHTF has also participated in the development of new indicators for measuring the implementation of MPDSR in countries. While notifications of maternal deaths tend to be increasing, the sustained institutionalization of MPDSR has been difficult to achieve and progress varies depending on country leadership and commitment. Although exceptions can be identified, death audit/review findings are underutilized in most countries, which is indicative of a problem with the process itself rather than with MHTF technical support. The challenges faced in strengthening MPDSR systems stress the importance of demand creation and community engagement for better outcomes from SRHR-MNH integrated service investments as well as the need to maintain systematic action to encourage earlier attendance by women at the health facility and build trust between providers and beneficiaries of care.

UNFPA has made a clear contribution at both the global and national levels towards increasing the commitment of governments and partners to end fistula. As lead for the Global Campaign to End Fistula, UNFPA/MHTF effectively coordinates an advocacy and knowledge sharing agenda that has helped to maintain fistula as a global priority. At the national level, the strategic positioning of UNFPA is enhanced by its partnership with governments and its convening role, which has advanced national strategies to end obstetric fistula. Building capacity for fistula treatment and care is the main thrust of programming in countries and tangible progress has been made through strategies linking competent surgeons with clients, with mobile teams, and with service delivery camps. However, in most countries, these services remain donor-dependent and have yet to be mainstreamed into the health system. Efforts to rehabilitate and reintegrate survivors into communities are at early stages overall. The rise in iatrogenic fistula (caused by medical treatment) is an emerging issue globally and requires renewed attention to safe surgical services and quality of care throughout all components of the MHTF.

The MHTF has been able to support integration of SRHR and MNH services to some extent and there is tangible evidence of progress in the integration of family planning into maternal health services across the care continuum. The MHTF supports each country to define the scope of integration between SRHR and MNH services according to their own opportunities and service priorities. However, integration of post-abortion care is inconsistently addressed. Moreover, the MHTF support to integrating both adolescent SRHR and sexual and gender-based violence (SGBV) is at an earlier stage of evolution and this task seems to be considerably harder as it requires midwives with an expanded skillset, more time and space (privacy), and attitudes that are respectful and non-judgemental. At the centre of the integration process, the midwife is a critical lynchpin to expanding access to a full range of SRHR and MNH services for women and girls. Yet, efforts to support midwifery-led integration are obstructed by weak infrastructure and a lack of equipment, two structural health system failures that the MHTF can only partially tackle. An important emerging challenge is the need to balance the opportunity and vision to develop a comprehensive approach to women's health across the life-course without increasing the risk of overburdening midwives and associated health systems.

The MHTF is oriented towards equality, human rights and values associated with ensuring equitable access to services for all women and girls but with uneven results so far. MHTF interventions supporting service access (midwifery training, EmONC and fistula) have resulted in expanding service delivery to underserved geographic areas and vulnerable populations, while also maintaining a spotlight on relevant social and economic determinants affecting MNH. However, the MHTF does not have a defined or explicit approach or process for identifying those most at risk or the most vulnerable. The MHTF lacks a framework for defining and operationalizing rights-based principles in programming, which leads to inconsistent application in country-based activities, including, for instance, varying attention to the need for respectful care. Because of limitations in the integration of SRHR and MNH, MHTF activities are less effective in ensuring that adolescent girls and women are empowered to access a full range of SRHR services, especially contraception, post-abortion care and, where legal, safe abortion services.

The MHTF method of combining technical knowledge, seed funding, and global partnerships in order to support country partners to tackle particular SRHR-MNH technical areas is a strength that positions it well to leverage catalytic results. The method allows the MHTF to provide high quality support in four critical technical areas and increases UNFPA credibility with country partners. The MHTF has produced an impressive range of global guidance, peer reviewed evidence papers and other policy documents. However, the potential behind many "catalytic" investments is still to be fully realized especially - but not only - given constraints to progress created by the ongoing COVID-19 pandemic (although these should be transient). Other stand-alone innovations and digital adaptations (such as mobile phone apps) have played a role in supporting results but are not, in themselves, necessarily catalytic or sustainable. The MHTF is currently addressing the twin challenge of firstly developing strengthened guidance that clearly defines what being catalytic means and secondly laying out the operational approach countries should take in order to build on and document catalytic effects more systematically.

The MHTF is benefitting from improved leadership and vision and the recently established Advisory Board supports more structured engagement with partners (including donors). These developments should help the MHTF address the several challenges it faces. These challenges include: positioning its strategic direction in relation to overarching UNFPA MNH; building SRHR-MNH integration across the life-course; overcoming bureaucratic constraints; and delivering clearer communication of results. Results data collected from countries tend to focus on outputs and build a cumulative picture of the MHTF activities, but they are less effective at helping identify the MHTF contribution to country-specific progress. The consequence is a difficulty in fully capturing the value of results achieved from the whole of the MHTF, including its strategic partnerships. The lack of community-facing links or investments into building demand for services is a visible gap, as are more

systematic interlinkages between the MHTF support to MNH investments and larger health systems strengthening and reforms.

UNFPA effectively used the MHTF to respond quickly and flexibly to the COVID-19 pandemic through programmatic efforts and reallocation of available resources to ensure continuity of essential SRHR and MNH services while protecting the safety of clients and providers. UNFPA

articulated a response in support of partner countries referencing key lessons learned from the West Africa Ebola outbreak, during which routine services were seriously disrupted causing high levels of preventable mortality, especially for women and children. The UNFPA/MHTF response included the development and dissemination of COVID-19-specific technical guidelines and protocols, the provision of personal protective equipment (PPE), other strategic support, such as transport vouchers for health personnel to get to work safely, and hospital triage support to ensure safe access to essential maternity services.

CONCLUSIONS

1. With the MHTF, UNFPA is a partner of choice providing visible and valued support to critical MNH priorities. The MHTF has evolved into a strong, focused and technically sophisticated tool for supporting MNH in the programme countries, especially in its four priority areas of midwifery, EmONC, MPDSR and fistula. The MHTF delivers support to programmes that are perceived to be of high quality, that address gaps in country health systems and that produce tangible results. At a global level, MHTF staff participate in and/or lead the development of a range of knowledge products whose impact extends beyond the 32 MHTF partner countries. It is a programme that delivers considerable thrust with a limited package of resources.

2. Midwifery is the anchor of the MHTF and the cornerstone of the UNFPA MNH response. Identified as the leading partner for midwifery, UNFPA has instigated major steps forward on the definition of midwifery practice (for example, standards of care, capacity and skills, and performance monitoring) that have been complemented by country-focused efforts to upgrade the education, training and deployment of midwives and initiatives to support their professionalization. The role of midwives is critical to promoting SRHR-MNH integration and to overcoming the three delays that lead to maternal mortality (delay in seeking care; in reaching the right level of care; in receiving the right care) particularly in promoting health-seeking behaviour among women and girls. However, the MHTF has not yet fully captured the pernicious effects of gender inequalities and power dynamics that affect health systems in programme countries.

3. The MHTF delivers value for money, both globally and for individual countries. Through leveraging global partnerships, deepening policy and technical coherence, and strengthening the quality of programme implementation, the MHTF has developed a programme model that delivers visible results and creates effective entry points for a range of interventions. To maximize these opportunities, the MHTF relies on a set of skills and a vision in the country office that are strong on systems strengthening, coordination, convening, advocacy and partnership building. Achieving optimal effects also relies on the country offices' ability to supplement the MHTF resources with core funds and to raise additional resources through engaging partners locally. At the global level, the MHTF has enabled UNFPA to influence the agenda on MNH and to deliver a wide range of policy and guidance products in all of the four technical areas that will influence MNH programming beyond the MHTF partner country context.

4. The MHTF is not clearly positioned within a holistic UNFPA MNH strategic framework. By focusing on four specific technical areas, the MHTF has carved out a defined expertise. However, at a global and organizational level, the MHTF is not aligned with or anchored in a UNFPA maternal

health strategy. As the main (but not the only) UNFPA programming vehicle into maternal health, this leaves a policy and strategy gap between the MHTF (as a programme delivering specific inputs) and the UNFPA MNH strategy at the global and organizational level. In turn, this gap makes it difficult to clearly identify the locus of UNFPA policy, strategy, and programming effort in relation to the transformative result of ending preventable maternal deaths. Meanwhile, at the country level, the issue is the agility of the MHTF, and whether it can position its interventions within a holistic SRHR-MNH strategy that is context specific to the programme countries themselves. The challenge for the MHTF is to maintain its technical focus (and well-defined offer of expertise and support), while remaining flexible to assist countries in addressing their priority needs in MNH.

5. If not addressed, critical gaps will limit the relevance and the sustainability of the MHTF investments. Investing in the supply of high-quality maternal services is necessary but not sufficient to ensure sustainable results. There is a need to engage with communities to address barriers to access, to overcome delays, to improve accountability and to better ground MHTF investments with affected populations. Furthermore, while the MHTF has helped countries identify and set standards for the supply-side and delivery of quality EmONC and related MNH services and care, it should also actively incorporate the views of women and girls and what they value in relation to SRHR-MNH integrated services, especially in relation to respectful care. While each of the four technical areas of the MHTF aims to influence and strengthen quality of care improvements, the indicators that enable quality of care measurement and tracking (especially including the experience of women who have been through the care of the health services) are insufficient and underutilized.

6. The MHTF has not yet been fully designed to deliver its “catalytic effect” systematically. The MHTF leverages its limited financial resources through investments which have, by and large, a catalytic potential and are, at times, catalytic when taken to scale with necessary leadership, sustained national commitment and resources. However, the MHTF is not sufficiently systematic in identifying or creating opportunities to engage national leadership for MNH in order to target the resource mobilization needed to take technical advances to scale. The realization of this catalytic potential depends on the ability of the MHTF to anticipate and prepare for the challenging shift from a relatively low-cost, intense technical process focused on developing a national policy or strategy to a much larger, longer-term, higher-spend, national scale-up of that policy. The absence of a strategy clearly positioned within the engineering of the programme itself and accompanied by a tried and tested toolbox to support the elevation of programme inputs in ways that generate the “catalytic effect” currently reduces the MHTF catalytic achievements.

7. The MHTF targets gender equality, human rights and equity, especially among adolescents, but does so unevenly. The MHTF has identified three rights-based principles upon which its strategy is based (accountability, quality of care, and equity in access), but it lacks a framework for defining and operationalizing rights-based principles in MHTF programming, which has led to uneven application of these principles in country-based activities, such as for quality of care. Furthermore, while the MHTF aims to target vulnerable women and girls through the application of the “leave no one behind” principle, it has yet to define or articulate an approach or process for identifying those most at risk or the most vulnerable. MHTF interventions supporting service access (midwifery training, EmONC and fistula) have resulted in expanded service delivery to underserved geographic areas and vulnerable populations. However, because of limitations in the integration of SRHR and MNH, MHTF activities are not as effective in ensuring that adolescent girls and women are empowered to access a full range of SRHR services.

8. Given its results and successes, the MHTF has considerable unrealized potential. The MHTF is a programme with a modest profile, whose strengths and accomplishments are not always well-

known. Not enough has been done, at UNFPA, to highlight its achievements, drive resource mobilization, position it strategically within a coherent MNH strategy and use the knowledge gained through the MHTF to help better shape the global agenda. This is also the consequence of a monitoring system that does not emphasize the use of a small number of readily available results indicators, which can be interpreted and presented in a manner that increases visibility for the MHTF in both UNFPA and the global arena. The MHTF image deficit, compounded by monitoring that lacks sufficient qualitative and contextual analysis, may also constitute an impediment to the mobilization of more funding and the pursuit of long-term engagement from partners. Ultimately, this may prevent the MHTF from being valued in relation to its actual contribution to maternal and newborn health, which this evaluation demonstrates is significant and multifaceted.

RECOMMENDATIONS

1 As the key UNFPA vehicle for SRHR-MNH integration and support, continue the MHTF and expand it into a new phase

The MHTF makes a visible contribution to maternal health in the countries where it is working and to the overall UNFPA maternal health response. The MHTF should continue into Phase IV with design adjustments taking into account the strategic and operational recommendations identified in this evaluation. In particular, an expanded theory of change should identify the larger landscape in which the MHTF operates and its specific contribution. Phase IV of the MHTF should serve as an opportunity to clarify the MHTF role and positioning in relation to other UNFPA investments into maternal health as well as the larger, global MNH landscape.

2 Position the MHTF within a comprehensive UNFPA maternal health strategy and action plan

The 2022-2025 UNFPA strategic plan is shaped around three transformative results, including ending preventable maternal deaths. In this context, it is not clear whether the MHTF is intended to serve as a limited, catalytic fund, channelling a specific set of technical and financial resources to defined elements of MNH, or is expected to encompass the entire UNFPA MNH programme (with other UNFPA programmes supporting important MNH results). Drawing on the MHTF experience, UNFPA should develop an organisational-level comprehensive maternal health strategy and action plan that clearly situates the MHTF and other UNFPA MNH efforts within a coherent organizational mandate with roles and responsibilities in relation to its objectives in maternal health and its broader remit on integrated SRHR-MNH.

3 Champion quality of care at the point of delivery, including respectful care

The MHTF approach to strengthening user-centred quality of care, including respectful care, is still at an early stage. The MHTF should invest in building country experience and global leadership on scaling up quality SRHR-MNH services at the point of implementation (from the user's perspective) and should champion respectful care especially, but not only, among midwives. This includes developing and integrating actionable programming into all MHTF technical areas and strengthening progress monitoring to enable lesson learning and scale-up of good practices.

4 Be more systematic about integrating community engagement across all MHTF activities

Community decisions about whether, when and how to seek care affect MNH outcomes. Currently, the main thrust of the MHTF has been focused on the supply of services. While the MHTF does not necessarily need to invest extensively in demand creation and community engagement itself, it should integrate and promote a more structured approach to community engagement as part of a broader strategy to generate increased demand for timely and accessible MNH services. This adjusted orientation should focus on increasing the timeliness and efficacy of decisions to seek care, to access family planning and SRHR services, to elect to deliver in a health facility, to build the interface of the midwife with the community, and to participate in death audits/reviews. It will require developing and deepening partnerships with others and investing in country office staff capacity and advocacy skills.

5 Engage partners, especially donors, more actively in the MHTF progress

The recently created Advisory Board is in the early stages of carving out its role and has been welcomed by partners. Donor engagement in the work of the MHTF, including as part of the Advisory Board, will foster visibility and support, as well as create potential opportunities in specific countries or settings. Over time, the MHTF should invest in the role and functioning of the Advisory Board in order to strengthen its accountability to funding partners, to increase its participation in shaping strategic direction and to support improved communication of results and performance.

6 Improve the strategic coherence and responsiveness of the MHTF

A key strength of the MHTF is its programme model, which offers countries access to strategic global partnerships, technical expertise and financial resources to seed-fund investments. The four technical areas promoted by the MHTF are insufficiently coordinated with each other however, and are not all equally well supported at the country level. In addition, as priorities evolve, the MHTF will achieve more traction with more flexibility in its programme model to respond to country priorities. It should thus aim to clarify and streamline the linkages and coherence among the four current technical areas. It should also consider options to selectively include other technical areas without sacrificing its well-defined programme model. The development of the MHTF Phase IV and associated theory of change creates an ideal opportunity to include these critical aspects.

7 Embed the focus on midwifery and the health workforce environment across the MHTF

As a key entry point and “gateway” to women’s health across the life course, midwives and the larger health workforce environment in which they operate constitute tangible health systems strengthening investments. The experience of women and girls highlights the role that skilled health personnel play in their perception of what quality care is. The MHTF progress and leadership on midwifery and the health workforce environment continue to create a key entry point for MNH. This should be further developed in Phase IV by investing more in embedding midwifery into community and primary care, integrating more focus on respectful care, and investing in health systems reforms, including the EmONC network expansion.

8 Invest more in MHTF core added values: SRHR-MNH integration and promoting catalytic results

The MHTF has two core element features that add value. The first is the fact that it is uniquely focused on integrating SRHR and MNH services and has made good progress in this area. The second is that the emphasis on driving catalytic results is integral to its delivery model and a cornerstone of the MHTF approach. In both these areas, the MHTF has made visible but

inconsistent and insufficiently documented progress. In Phase IV, the MHTF should develop detailed and actionable guidance for country offices to support design, partnership development, and implementation. This should include promoting, documenting and communicating on SRHR-MNH integration and the MHTF catalytic role.

9 Refine results monitoring to improve understanding and communication about the MHTF added value in different contexts

Although detailed, the current results-oriented monitoring (ROM) system does not easily enable the MHTF to identify and communicate its results and contribution as a United Nations programme working in an often crowded field. The MHTF should adapt its current approach to track fewer, more immediately relevant results that can support a clear narrative about the MHTF contribution and value-added in varied settings. The results-oriented monitoring system should have a greater focus on perceptions of change among stakeholders by supplementing a shorter indicator framework with reporting that makes use of qualitative information on the MHTF contribution to, and progress toward, outcomes. This would support increased understanding about what is working, where and why.

10 Invest in innovative funding approaches to attract an expanded donor base

The MHTF should develop a comprehensive funding model and financing plan to support Phase IV. The plan should be linked to its new programme of work and be well situated within a UNFPA maternal health strategy in order to enable the MHTF to address (and reverse) declining commitments, as well as the negative effects of onerous financial management processes. The plan should also foresee innovative funding options to generate country engagement and commitment to SRHR-MNH integration, for example through matching arrangements. Innovative funding modalities could extend the value of MHTF resources, leverage additional funds from core and other partner sources, and help open up additional programme priorities.

Read the **evaluation report** of the Mid-term evaluation of the MHTF Phase III, 2018-2022 [here](#)



INTRODUCTION OF THE CASE STUDY

Mid-term evaluation of the MHTF Phase III, 2018-2022

The purpose of the mid-term evaluation is to assess the performance of the Maternal and Newborn Health Thematic Fund (MHTF) in providing catalytic support through country-owned and driven interventions to improve maternal and newborn health and rights in 32 high-mortality countries.¹ It will assess the contribution of the MHTF to strengthen health systems through its focus on:

- Four components of health systems: workforce, service delivery, health information systems, leadership and governance
- Four integrated technical areas: midwifery, emergency obstetric and newborn care (EmONC), maternal and perinatal death surveillance and response (MPDSR), obstetric fistula and other morbidities.

It will also assess the MHTF contribution to:

- Increased equity in access to sexual reproductive health and rights (SRHR) information and services, including for those furthest behind
- Improved quality of care
- Higher accountability
- The promotion of gender equality and human rights in the context of maternal and newborn health (MNH).

The evaluation has two principal objectives:

1. **Analyse how and to what extent** UNFPA support to MNH has been guided by the theory of change and results framework as set out in the MHTF Phase III Business Plan (2018-2022)² and assess the progress made thus far in the implementation of the MHTF strategic interventions in the four overlapping and mutually reinforcing MHTF outcomes.
2. **Facilitate learning and capture good practices** from the MHTF across its components and areas of health system strengthening to inform the implementation of the MHTF current phase, other ongoing programmes with a link to MNH, as well as UNFPA future programmatic interventions in support of MNH and broader SRHR.

While the results of the mid-term evaluation are expected to feed into the implementation of the MHTF through to the end of its current phase, they will also inform the reflection on strategic directions, programmatic scope as well as the operating model for the MHTF post 2022.

Temporal and geographical scope

The evaluation will cover the period since 2018 under the current MHTF Business Plan (2018-2022). Its geographical scope includes all 32 countries in the five UNFPA regions of operation where MHTF interventions are currently being undertaken: Western and Central Africa; Eastern and Southern Africa, Asia and the Pacific, Arab States, and Latin America and the Caribbean.

Evaluation questions

The evaluation examines nine evaluation questions.

¹ The global midwifery programme works in over 100 countries & the global Campaign to End Fistula supports 55+ countries (including all 32 MHTF countries). This expanded remit beyond the MHTF partner countries will be explored further in the evaluation.

² <https://www.unfpa.org/pcm/node/18565>

Table 1: Evaluation questions by area of investigation

Evaluation Questions
Area of Investigation 1: Midwifery
Evaluation Question: To what extent has the MHTF contributed to ensuring the education, training, and deployment of an adequately skilled/competent, motivated, and sustainable midwifery workforce?
Area of Investigation 2: Emergency obstetric and newborn care
Evaluation Question: To what extent has MHTF supported ministries of health to design, strengthen and scale-up a national network of referral maternity facilities capable of providing quality SRHR services and MNH care, including EmONC?
Area of Investigation 3: Maternal and perinatal death surveillance and response
Evaluation Question: To what extent has the MHTF contributed to firmly establish the main components of the MPDSR programme; to support its implementation at national scale; and to increase the notifications of maternal deaths and strengthen the quality of maternal death reviews (MDRs) and implementation of the “response” component?
Area of Investigation 4: Obstetric fistula and other obstetric morbidities
Evaluation Question: To what extent has the MHTF contributed to the capacity of governments to develop, implement and monitor national strategies for ending fistula cases that are founded on prevention, access to quality treatment of fistula cases and other obstetric morbidities, and social reintegration of obstetric fistula survivors?
Area of Investigation 5: Integrated MNH and SRHR
Evaluation Question: To what extent has the MHTF contributed to a strengthened integration between maternal health and SRHR with a view to achieving quality service delivery, increasing client satisfaction, and stimulating greater public demand for SRHR services?
Area of investigation 6: Equitable and accountable access
Evaluation Question: To what extent has the MHTF contributed to strengthening the availability and quality of health service delivery and health information system to meet the diverse and differentiated needs of the women, newborns, and adolescent girls including in the lowest wealth quintiles, living in hard-to-reach areas, facing discrimination (based on identity, ethnicity, and/or faith) and living with disabilities?
Area of investigation 7: A catalytic role
Evaluation Question: To what extent has the MHTF fulfilled its catalytic role enabling UNFPA to ‘punch above its weight’ in support of MNH outcomes and integration with SRHR?
Area of investigation 8: MHTF governance and management
Evaluation Question: To what extent have MHTF management mechanisms and internal coordination processes contributed to the overall performance of the programme. Specifically, how have these facilitated: (i) resource mobilization for the MHTF; (ii) efficient and effective collaboration with other UNFPA programmes; (iii) the integration of MNH within country programmes; and (iv) an effective oversight and guidance by the MHTF Advisory Committee?
Area of investigation 9: COVID-19
Evaluation Question: To what extent has the MHTF been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level due to the COVID-19 pandemic?

1.1.2 Country case studies

The evaluation is structured around a series of country case studies, augmented by global and regional data collection. A case study-centred approach allows for the exploration of the MHTF in widely differing contexts and settings. The MHTF takes different shapes or paths depending on UNFPA interaction with other health actors and formulates responses to opportunities and barriers in different ways depending on a range of variables that are country specific.

The specific purpose of the case studies is to investigate the design and implementation of interventions under Phase III of the MHTF, and to assess the results achieved within the specific context of programme countries. The evaluation encompasses four field-based country case studies (Benin, Sudan, Uganda and Zambia) and two desk-based country case studies (Bangladesh and Togo) mapped in Figure 1. The case studies are not intended to present a statistically valid sample, nor are they representative of the entire population of programme countries.

Figure 1: Map of field and desk-based country case studies



The designations employed and the presentation of material on the map do not imply the expression of any opinion whatsoever on the part of UNFPA concerning the legal status of any country, territory, city or area or its authorities, or concerning the delimitation of its frontiers or boundaries.

Countries were selected for the field and desk studies to provide a set of variable examples of MHTF support in different regions and with varying MNH indicators. For example, some countries had high maternal mortality ratio (MMR) and/or neonatal mortality ratios (NMR) despite declining fertility. Some countries also offer a mix of conflict and humanitarian contexts, differing access to development assistance for health, or other factors that added nuance or complexity.

Objectives of the field country case studies

The field-based country case studies aim to provide insights into the evaluation questions and a comprehensive nuanced picture of programme actions and their results. They allow the evaluation to explore the evaluation questions in greater depth than would be possible in desk studies. The country case studies are not individual programme evaluations at country level. Their objectives are to:

- Provide input for answering the evaluation questions and causal assumptions
- Triangulate data collected from other sources and respondents with qualitative and quantitative information collected in country
- Identify lessons learned.

Approach and methodology

Each field country case study uses a theory-based evaluation approach based on the theory of change and causal assumptions developed for UNFPA activities related to MNH. The theory of change is described in detail in the Section 1.4 below. The causal assumptions form the basis of the evaluation matrix (Annex 1) and enable the evaluation to determine the contribution of UNFPA to MNH outcomes in the theory of change.

The data collection methods used in each field country case study are:

- Identification and review of core documents at country level, including country programme documents and annual workplans, programme review and evaluation documents, monitoring and progress reports, national plans and programmes, minutes of coordination meetings and documents produced by other bilateral and multilateral agencies supporting MNH
- Review of financial data regarding programme investments
- Key informant interviews with a wide range of stakeholders at national level (Annex 2)
- Visits to programme and service delivery sites, including interviews with service providers, managers and community members
- Interviews and, where possible, group discussions with individuals accessing SRHR and/or MNH services
- A debriefing workshop with participation of UNFPA country staff. This allowed the evaluation team to present preliminary observations and receive feedback on any gaps in the collected data, factual errors or misrepresentation.

The evaluation also uses other methods, including an online survey of key stakeholders, interviews undertaken at global and regional level and a comprehensive global document and data review to ensure coverage of all elements of the MHTF.

The resulting evaluation data was analysed and interpreted jointly by the evaluation team. Each element of evidence was recorded in the evaluation matrix (Annex 1) in relation to relevant evaluation questions and causal assumptions. This allowed the evaluation team to triangulate evidence from different sources and to develop the findings presented in Section 3.

MHTF overall theory of change

This section presents the overall theory of change for the MHTF as developed during the inception phase, updated during data collection, and refined during the analysis and reporting stages of the evaluation. The theory of change presented here attempts to capture all the different ways in which the MHTF provided catalytic support through country-owned and driven interventions to improve MNH and rights in vastly differing contexts and at different levels (global, regional and national).

In this sense, nowhere has the evaluation team seen this theory of change implemented in its entirety. In fact, the theory of change encompasses a wide range of activities and a multi-layered chain of results, which are difficult to implement effectively and to sustain given the current staffing and financial resources available to UNFPA in the different MHTF programme countries.

The MHTF theory of change (Figure 2) should be 'read' from the bottom to the top and from left to right. The MHTF specific inputs, activities, outputs, and outcomes are presented within a larger landscape, while the chain of effects is clearly demarcated within a blue-lined box. Expected COVID-19 effects are laid out in purple and describe how the UNFPA strategy and programmatic guidance on responding to COVID-19 is expected to impact on specific areas of the MHTF. These identify the relevant UNFPA policies, the activities undertaken, and the outputs and outcomes expected. The broader social and economic determinants that affect MNH outcomes (and which the evaluation

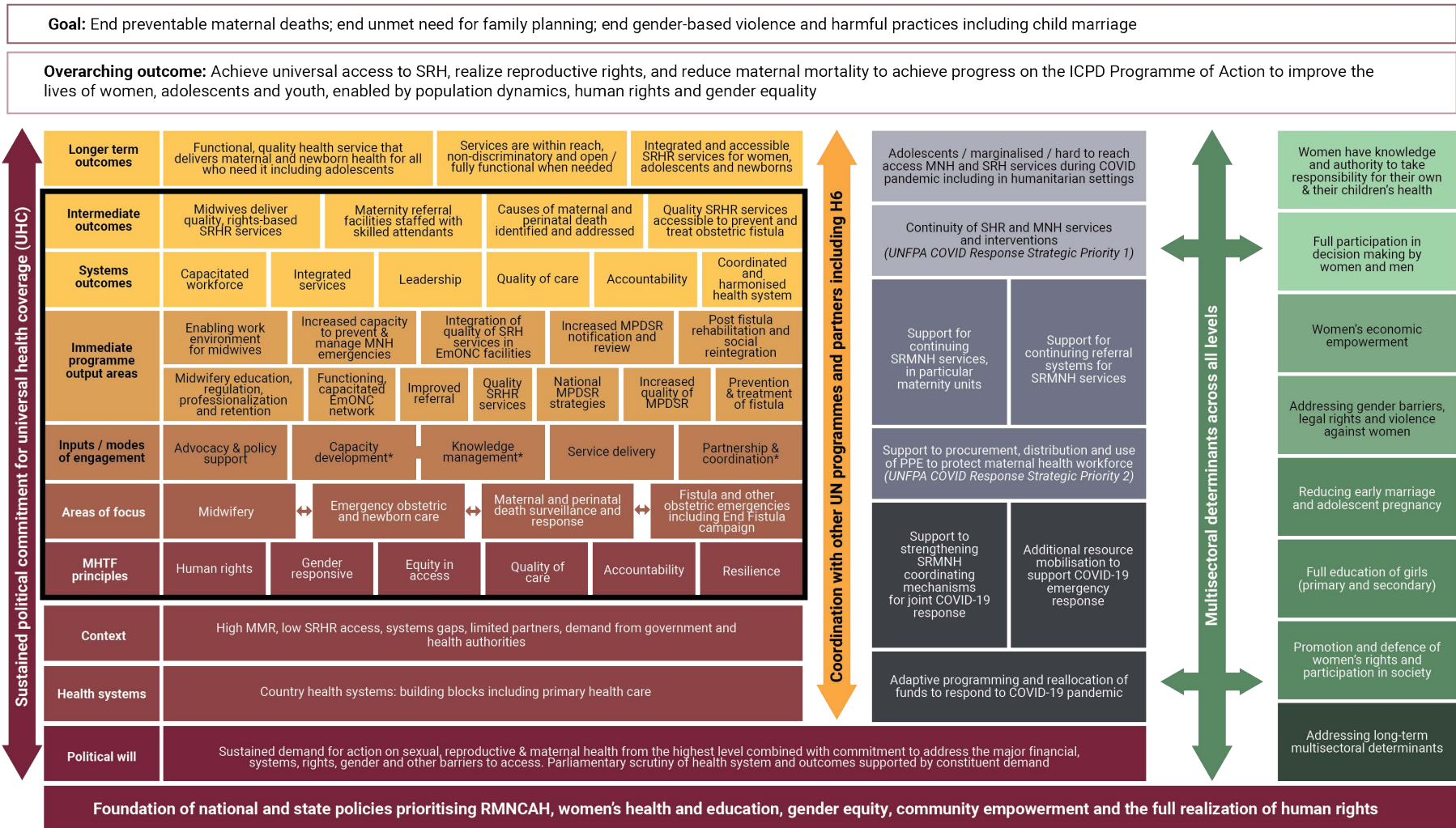
does not assess) are laid out in green on the right-hand side. The vertical arrows identify three critical cross cutting dimensions: political will, coordination across all stakeholders, and multisectoral determinants. The specific chain of effects is explained in Table 2.

Following the MHTF theory of change (Figure 2), the specific segments of the theory of change to be evaluated have been extracted and are magnified in Figure 3 in order to map the placement of the evaluation questions and corresponding assumptions thus linking the theory of change directly to the evaluation matrix available in Annex 1.

Table 2: A key to help read the refined MHTF theory of change

Line of the theory of change (from the bottom)	Explanation
Foundation	The institutional setting, range of laws, and public policies that are the foundation of every country's approach to governance, health and welfare.
Political Will	The presumption that countries are invested in SRHR and maternal health and have the will to engage across political levels to improve outcomes.
Health Systems	A recognition of the health system that will be in place in all countries at national and sub-national levels. The MHTF will engage in some elements of some health system building blocks but largely its efforts area based on what is already in place.
Context	The specific context that MHTF partner countries share.
MHTF Principles	The principles that shape the approach taken by the MHTF in developing and implementing its activities and support.
Areas of Focus	The four major and inter-related areas of engagement around which the MHTF focuses its work.
Inputs/Modes of Engagement	The five modes of engagement which together define the main vehicles for the types of support and specific inputs provided by the MHTF.
Immediate Programme Output Areas	These are the expected direct outputs from MHTF inputs and a critical chain of effect to make visible and assess.
Systems Outcomes	The broader outcomes expected to result from programme outputs and which MHTF will aim to shape and contribute towards.
Intermediate Outcomes	The outcomes linked to the four areas of focus identified in the MHTF Business Plan.
Longer-term Outcomes	The strategic outcomes towards which the MHTF is contributing.
Over-arching Outcomes	The long-range outcomes identified in the MHTF Business Plan change model.
Goal	UNFPA organizational goals laid out in the UNFPA strategic plan, 2018-2021.

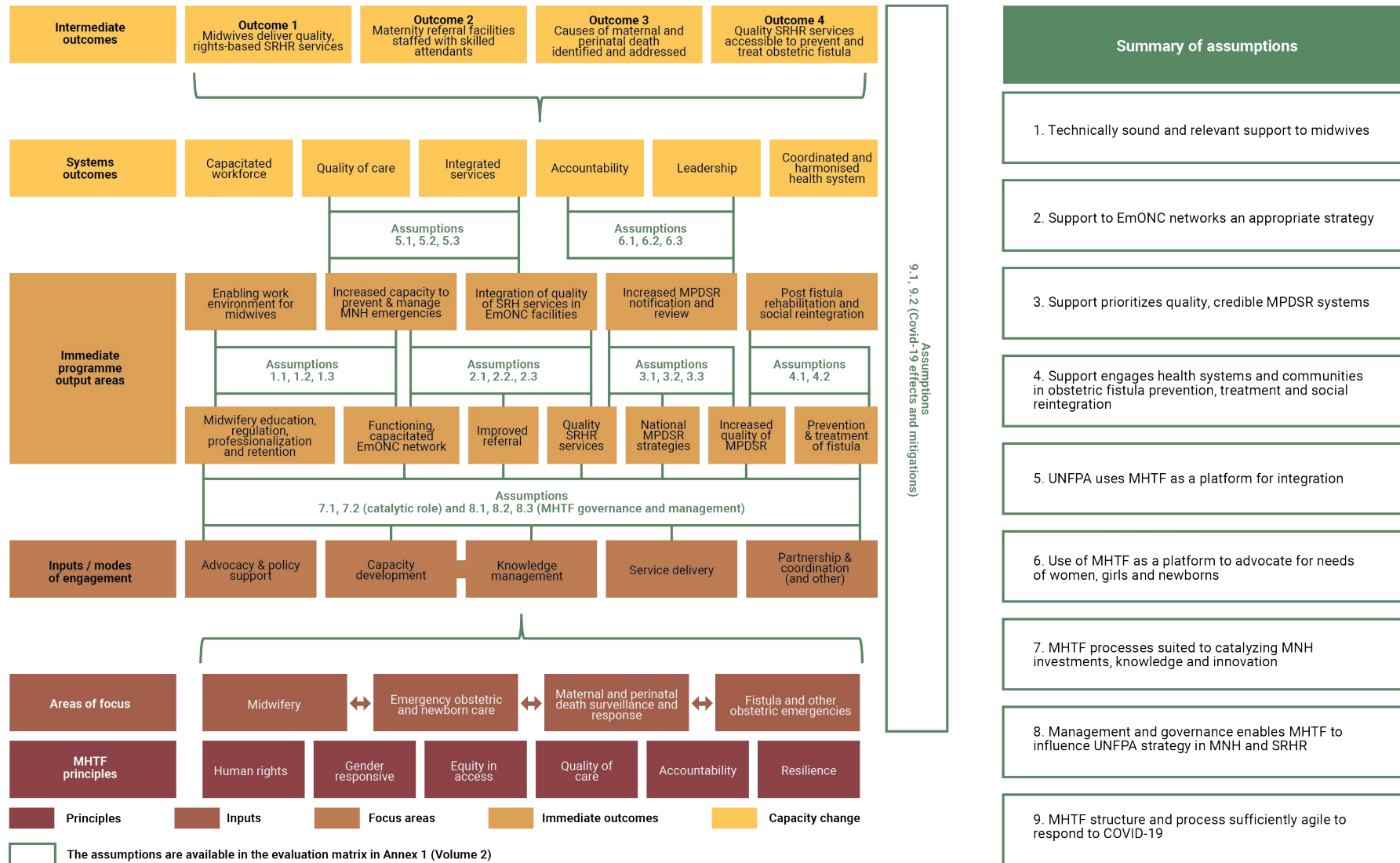
Figure 2: Overall theory of change for UNFPA support to maternal and newborn health



Foundation Context Inputs Immediate outcomes Capacity change COVID-19 inputs Results/impacts Multisectoral determinants of mortality

* In practice, capacity building and knowledge management were often treated in financial and activity reports as interchangeable. They have been linked here to reflect that. No expenditure was badged as 'coordination'. The fifth MOE was usually just 'other' and was small.

Figure 3: Focused MHTF theory of change with evaluation assumptions mapped out



Carrying out the field-based case study in Uganda

Data collection activities

The Uganda country case study mission was carried out by a team composed of two international consultants, one based in Uganda. Data collection was undertaken between 10-25 May 2021. The case study mission was preceded by a review of documents provided by the Uganda UNFPA country office. These were supplemented by documents gathered from key informants during the field mission where relevant (see Annex 4).

The evaluation team carried out a wide range of interviews with key stakeholders for UNFPA activities and support to MNH (Annex 2), notably:

- The UNFPA Uganda staff including the deputy representative and programme and technical specialists in MNH, family planning, adolescent SRHR, primary health care (PHC), finance and monitoring and evaluation
- Senior policy makers and managers at the Ministries of Health (MoH) and Ministry of Education and Sports (MoES)
- Technical specialist and programme supervisors and focal points for sexual reproductive health (SRH), midwifery, elimination of fistula, reproductive health related cancer, EmONC, MPDSR, and sexual and gender-based violence (SGBV)
- Midwives' Professional Association and regulatory body
- The director of the Academy of Health Sciences
- Civil society organizations working on or adjacent to MNH
- Staff of The World Bank
- Staff of the most active development partners engaged in supporting MNH in Uganda and/or supporting UNFPA
- The evaluation team also carried out interviews with service providers and a small number of community members.

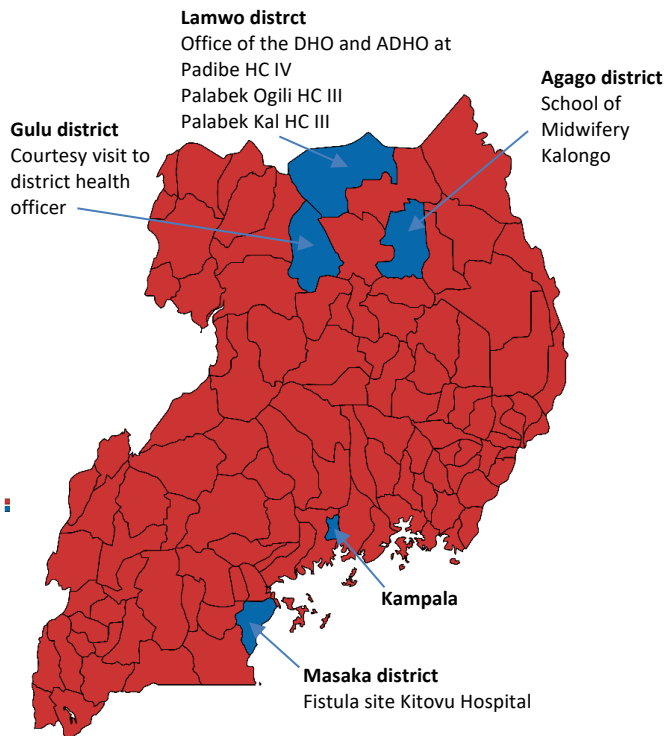
Additionally, the evaluation team conducted visits to hospitals and health centres delivering maternal and newborn services. The sites visited were located in (i) Kampala: (ii) Gulu, Lamwo and Agago districts in the Northern region/Acholi sub-region and Masaka district.

The visited sites were chosen to:

- Provide the evaluation access to hospitals and health centres (HC) that would most likely reflect the investments made by UNFPA with MHTF resources in support of MNH including one or more of the four focus areas: midwifery, EmONC, MPDSR and fistula.
- Ensure that sites were visited in both urban and rural settings and include multiple sites across more than one state.

The figure below provides an overview of administrative regions in Uganda and highlights the location of site visits by the evaluation team.

Figure 4: Sites visited in Uganda



Limitations

The Uganda case study was undertaken at a time when the COVID-19 pandemic made most aspects of travel and in-person meetings very difficult. As a result of this situation, three important limitations in the evaluation approach and methodology are noted with mitigating factors.

Firstly, as the evaluation took place during the second year of the COVID-19 pandemic, a number of challenges and restrictions remained in place. The international consultant was unable to travel to Uganda, which meant that the international consultant based in Kampala undertook the site visits alone. Internet connectivity and Zoom links had an effect on the ability of the evaluation team - especially the international consultant - to connect with the MoH and other stakeholders during the data collection period.

Secondly, the sample of site visits was small and not as representative of service provision in maternal, newborn or SRHR care throughout the country as would normally be the case in this type of evaluation; facilities from four districts were visited.

Thirdly, the main focus of data collection for the Uganda case study has been key informants working in government services and its partners on MNH in relation to the four priority thematic areas. Due to the limitations explained above, the evaluation team had limited contact with individual users of the services.

In mitigation, the consultants were in constant communication. Furthermore, increased efforts were made to triangulate data from a wide range of sources. Overall, despite the limitations identified, the evaluation team is confident that the data collected supports the validity of the findings reported in Section 3. The data and information collected are presented in the evaluation matrix in Annex 1.

NATIONAL MATERNAL AND NEWBORN HEALTH CONTEXT AND PROGRAMME RESPONSE

Uganda: Context and health setting

Uganda has one of the youngest and most rapidly growing populations in the world, with an estimated population of 42.5 million and a population growth rate of 3.34 per cent. Twenty-five per cent of the population live in urban areas and 75 per cent are adolescents and young people. High population growth results in an additional 1 million Ugandans annually. This has important implications for health planning and is further compounded by challenges such as rapid urbanization, poor waste management, high poverty, unemployment, environmental degradation and inadequate infrastructure.³ The country's north and northeast lag even further behind developmentally than the rest of the country as a result of long-term conflict and periodic natural disasters. In addition, Uganda hosts Africa's largest refugee population for those escaping conflict from the Democratic Republic of Congo, South Sudan and other nearby countries – 1.4 million refugees, of which 82 per cent are women and children.⁴

The Human Development Index for Uganda in 2019 is .544, ranking the country in the low human development category and positioning it at 159 out of 189 countries.⁵ Additionally, Uganda has a Gender Inequality Index of .535, ranking it 131 out of 162 countries for which this was measured.⁶ The Gender Inequality Index reflects gender-based inequalities in three dimensions: reproductive health, empowerment and economic activity, all of which contribute to the overall context for maternal and reproductive health.

Social and economic determinants of maternal health

The Government of Uganda (GoU) has made significant progress in developing legal frameworks and policies to protect women's human rights and advance gender equality. However, women in Uganda still face discrimination and marginalization due to slow change in attitudes about the role of women in Ugandan society and the culture and practices of institutions.⁷ Several important legal reform efforts have been pending for decades in relation to family laws and those relating to sexual offences. Violence against women remains a major obstacle to the empowerment of women.

The draft MoH reproductive, maternal newborn, child and adolescent health (RMNCAH) "sharpened plan" (road map) for 2020/21 to 2025/26 lists a range of bottlenecks or barriers to accessing essential health care, with a strong focus on service delivery or supply-side factors such as leadership and management, financing, human resources, infrastructure, the supply chain, and quality of care. Less attention is given in the road map to addressing issues of community ownership and demand generation, even though the document acknowledges how social norms and cultural beliefs inhibit access especially for facility births and contraceptive services.⁸ Nearly 6 in 10 women (59 per cent) reported at least one problem in accessing health care for themselves; the most frequent obstacle women mentioned was getting money for treatment (45 per cent).⁹ A 2016 study by researchers from Makerere University concluded a mother's education and employment status are key factors that bear on her welfare during pregnancy and birth and recommended that efforts to enhance

³ Ministry of Health Uganda, Third National Health Policy: Towards Universal Health Coverage. March 2021.

⁴ UNFPA 2020. Country Programme Document for Uganda (draft, 9 November 2020)

⁵ UNDP 2020. Human Development Report, Uganda. http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/UGA.pdf. Downloaded 22 September 2021

⁶ Ibid.

⁷ UN Women: <https://africa.unwomen.org/en/where-we-are/eastern-and-southern-africa/uganda>. Downloaded 22 September 2021.

⁸ MoH Uganda. 2020. Reproductive, Maternal, Newborn, Child, Adolescent and Health Aging Sharpened Plan for Uganda 2020/21 – 2025-26. November 2020.

⁹ Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016.

female education, keep girls in school, address early marriage and target scholarship programmes would help to attain favourable maternal health outcomes.¹⁰

Brief outline of the Ugandan health system

The health system in Uganda involves a well-defined network of facilities that are classified into levels based on the services they provide and the catchment area they are intended to serve (Table 3). Of the almost 7,000 facilities in Uganda, approximately 45 per cent are in the public sector, 40 per cent are private for profit and 15 per cent are private, not-for-profit. They cover 135 districts in four regions (central, eastern, northern and western).

Table 3: Categories of health facilities in Uganda¹¹

Level	Population	Services provided
(Health centre I)	not defined	Community-based preventive and promotive health services. Village health community or similar status.
Health centre II	5,000	Preventive, promotive and outpatient curative health services, outreach care, and emergency.
Health centre III	20,000	Preventive, promotive, outpatient curative, maternity (BEmONC), inpatient health services and laboratory services.
Health centre IV	100,000	Preventive, promotive outpatient curative, maternity (EmONC), inpatient health services, emergency surgery and blood transfusion and laboratory services.
General hospital	500,000	In addition to services offered at HC IV, provides other general services. Sites for in-service training, consultation and research to community-based.
Regional referral hospital	2,000,000	In addition to services offered at the general hospital, offers specialist services, such as psychiatry, ear, nose and throat, ophthalmology, dentistry, intensive care, radiology, pathology, higher level surgical (Fistula).
National referral hospital	10,000,000	Comprehensive specialist services; involved in teaching and research (Fistula).

It is estimated that 86 per cent of the population resides within 5 km of a health facility.¹² However, while the overall number of the health workforce has increased from 45,000 in 2008 to 118,236 in 2020, the overall staffing level is 74 per cent and workforce density of 1.6 per 1,000 which falls short of the 4.45 per 1,000 population threshold set by WHO for progress towards universal health coverage (UHC). Further, staffing level for HC II is much lower at 55 per cent.¹³ This is the health facility that is closest to the community, and which is supposed to provide basic health services as the first point of contact for 80 per cent of the population (mainly rural).

Although the Health Sector Development Plan (HSDP) prioritizes maternal health, PHC facilities, where 73 per cent of deliveries are conducted, are not adequately staffed or equipped to ensure 24-hour coverage. For example, the percentage of health facilities having over 95 per cent availability of a “basket of commodities” dropped to 46 per cent in 2019/20 from 53 per cent the year before, well below the HSDP target of 75 per cent. (The percentage of health facilities reporting availability of

¹⁰ Atuhaire, R. and Kaberuka, W. 2016. Factors Contributing to Maternal Mortality in Uganda. African Journal of Economic Review, Volume IV, Issue 2. July 2016.

¹¹ MoH Uganda. 2018. National Health Facility Master List 2019.

¹² Uganda Bureau of Statistics (UBOS). 2018. Uganda National Household Survey 2016/17 Report.

¹³ MoH Uganda. Human Resources for Health Strategic Plan 2020-2030. March 2021.

RMNCAH commodities was even lower at 33 per cent.)¹⁴ Functionality of HC IVs are suboptimal due to poor infrastructure and inadequate staffing. The proportion of HC IVs offering comprehensive emergency obstetric and newborn care (CEmONC) services increased slightly from 47 to 51 per cent between 2018/19 and 2019/20 (below the target of 60 per cent).¹⁵

Overview of maternal and newborn health in Uganda

Maternal and newborn data and trends

Uganda has made progress towards reduction of maternal and perinatal mortality. Maternal mortality has declined from 438 in 2011 to 336 per 100,000 live births in 2016; in the same time frame, infant mortality dropped to 43 deaths per 1,000 live births from 54 deaths per 1000 live births. However, neonatal mortality has stagnated at 27 deaths per 1,000 live births falling short of the HSDP (2015/19) target of 16 deaths per 1,000 live births.¹⁶

Although fertility has declined since 2000, it remains high at 5.4 children per woman; and one-quarter of adolescent girls (age 15-19) have begun childbearing. Teenage childbearing has remained stable since 2006. Use of modern contraception among currently married women increased from 14 per cent in 2000/01 to 35 per cent in 2016. Unmet need for contraception among married women is estimated to be 28 per cent; it is higher in rural areas (30 per cent) than in urban areas (23 per cent). Nearly half (45 per cent) of women surveyed discontinued episodes of contraceptive use, with the highest discontinuation rates for hormonal, short-term methods (67 per cent and 52 per cent for pills and injectables, respectively). Unintended pregnancies are still very high, with nearly 2 out of 5 of last pregnancies wanted later or not wanted.¹⁷

The leading causes of maternal deaths reported through the MoH health management information system (HMIS) in 2019/20 were haemorrhage (42 per cent), infections (12 per cent), hypertensive disorders of pregnancy (8 per cent), unknown (10 per cent) and pregnancy-related sepsis (6 per cent). Abortion and abortion complications accounted for 10 per cent (twice as much as for 2018/19). Thirty-six per cent of maternal deaths occurred among young mothers aged 24 years or younger.¹⁸ The main causes of neonatal deaths (2015) were birth asphyxia (28.6 per cent), prematurity (27.9 per cent) and sepsis (18.2 per cent).¹⁹

Financing maternal and newborn health in Uganda

After a period of steady increases in government spending on health in Uganda, per capita health spending has dropped by USD 20 since 2010. Likewise, health expenditures as a percentage of gross domestic product (GDP) rose and fell during the same time frame to 6.5 per cent, lower than the percentage in 2000. (Figure 5) In budget terms, the GoU allocation to health as a per cent of the total government budget increased from 6.9 per cent (2015/16) to 7.2 per cent (2019/20) though still far from the 15 per cent target. Whereas the proportion of GoU contribution dropped to 57 per cent from 64 per cent during the same period, the nominal budget allocations have increased significantly

¹⁴ MoH Uganda. Annual Health Sector Performance Report, Financial Year 2019-20.

¹⁵ MoH Uganda. Annual Health Sector Performance Report, Financial Year 2019-20.

¹⁶ Unless otherwise noted, the data in this section comes from the 2016 UDHS: Uganda Bureau of Statistics (UBOS) and ICF. 2018. Uganda Demographic and Health Survey 2016.

¹⁷ Performance Monitoring for Action/Uganda,

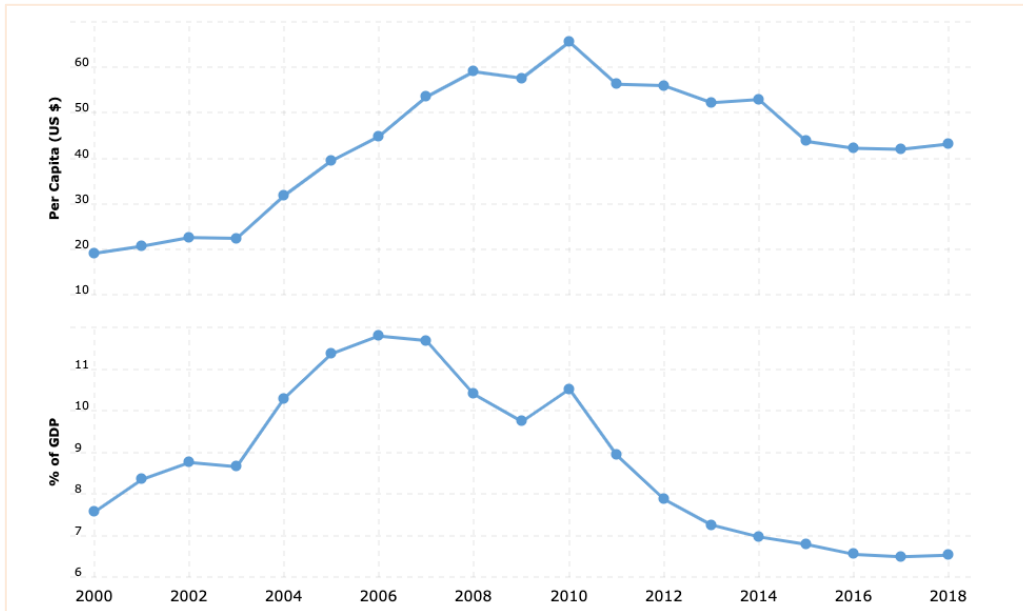
https://www.pmadata.org/sites/default/files/data_product_results/Uganda%20Phase%201%20Results%20Brief_Final_1.pdf, downloaded on September 25, 2021.

¹⁸ MoH Uganda. Annual Health Sector Performance Report, Financial Year 2019-20.

¹⁹ UNICEF. Maternal and Newborn Health Disparities in Uganda. <https://data.unicef.org/resources/maternal-newborn-health-disparities-country-profiles/>. Downloaded on September 25, 2021.

during the last two years. This is the result of the enhancement of salaries for medical workers and increases in external funding from the Global Fund, GAVI and the World Bank supported projects.²⁰

Figure 5: Government spending on health in Uganda (per capita health expenditures in USD and health expenditures as per cent of GDP), 2000-20218.



Source: Based on World Bank Data Bank analysis. <https://www.macrotrends.net/countries/UGA/uganda/healthcare-spending>

UNFPA maternal and newborn health programme priorities in Uganda

Strategic orientation and programmatic approach

The period for the mid-term evaluation of MHTF coincides with the end of UNFPA Uganda 8th Country Programme (CP8) and the initiation of the 9th Country Programme (CP9) in 2021, both of which share the strategic goal of contributing to universal access to integrated SRH information and services by women and young girls and the achievement of the three transformational goals as per the UNFPA strategic plan 2018-2021.

The CP9 outlines three main programmatic areas: SRH, gender equality and women’s empowerment, and population dynamics. (CP8 included these three areas, plus adolescents and youth as a separate outcome; in CP9, the adolescent and youth component is integrated across the other programmatic areas.) UNFPA prioritizes the strengthened integration of SRH services and gender-based violence (GBV) prevention and support services and targets young people aged 15-24 years and women of reproductive age, including those in hard-to-reach communities, ethnic minorities, refugees, internally displaced and migrant populations. Both supply and demand components underpin the UNFPA Uganda SRHR interventions, with efforts to increase capacity of the PHC system to provide universal access to and coverage of high-quality integrated SRHR, HIV and GBV services and to ensure that women and young people are empowered to make informed choices and utilize those services.

UNFPA Uganda budgets and expenditures

In 2020, the UNFPA Uganda programme expenditures were approximately USD 18.5 million, of which 63 per cent was spent on “integrated SRHR” services, followed by 20 per cent for gender equality, 10 per cent for youth and 6.5 per cent for population dynamics. UNFPA Uganda has seen an increase of 44 per cent in programme expenditures between 2018 and 2020, due to successful efforts to

²⁰ MoH Uganda. Annual Health Sector Performance Report, Financial Year 2019-20.

mobilize resources from bilateral donors to advance SRHR and GBV programmes. While the core funded budget (resources allocated from UNFPA headquarters) also rose between 2018 and 2020, the percentage of funding that core resources represent within the overall budget correspondingly decreased.

Table 4: Distribution of UNFPA Uganda expenditure (USD) across programme areas and divided by core and all sources of programme funding, 2018-2020

Programme Area	2018	%	2019	%	2020	%	Total 2018-2020	%
Integrated SRHR services	8,893,716	69.5	9,187,951	60.5	11,637,179	62.7	29,718,846	63.9
Adolescents and youth	1,376,155	10.8	2,408,397	15.9	1,935,460	10.4	5,720,012	12.3
Gender equality	1,971,621	15.4	2,847,515	18.7	3,772,460	20.3	8,591,596	18.4
Population dynamics	552,483	4.3	743,775	4.9	1,203,330	6.5	2,499,588	5.4
Total	12,793,975		15,187,638		18,548,456		46,530,042	
Of which, UNFPA core funding	2,836,221	22.1	3,235,637	21.3	3,425,975	18.5	9,497,833	20.4

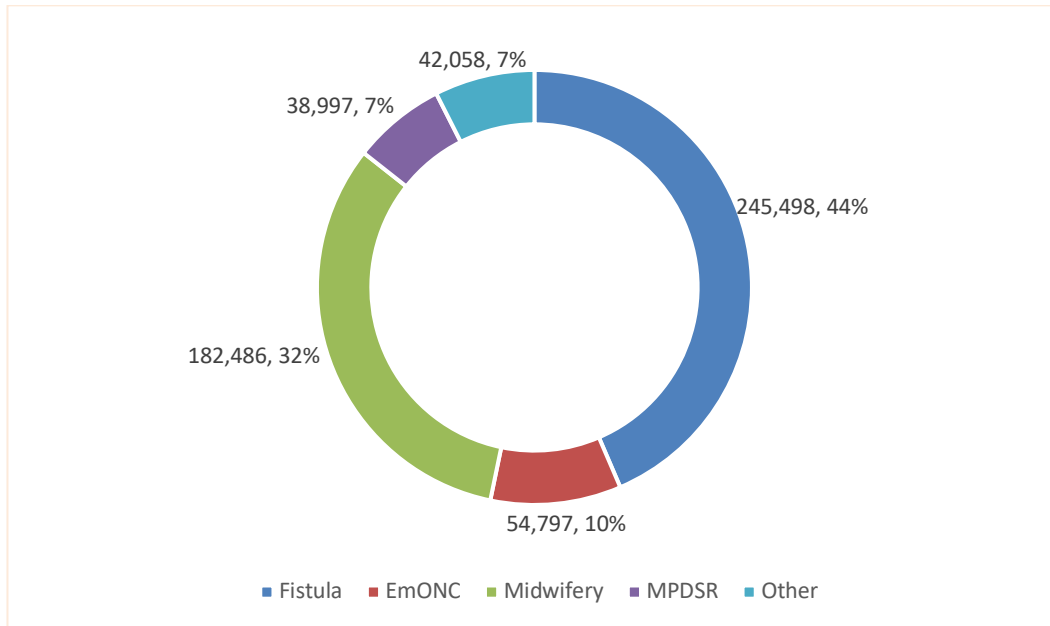
Table 5 shows MHTF expenditure as a proportion of all UNFPA Uganda expenditure by year. The MHTF expenditures represent 2.4 per cent of the overall budget for Integrated SRHR services and 1.5 per cent of total programme expenditures between 2018 and 2020.

Table 5: UNFPA Uganda total programme and MHTF expenditures by year

Year	Total UNFPA expenditure USD	MHTF expenditure USD (%)
2018	12,793,975	225,819 (1.8%)
2019	15,187,638	202,152 (1.3%)
2020	18,548,456	233,586 (1.3%)
Total	46,530,042	661,157 (1.4%)

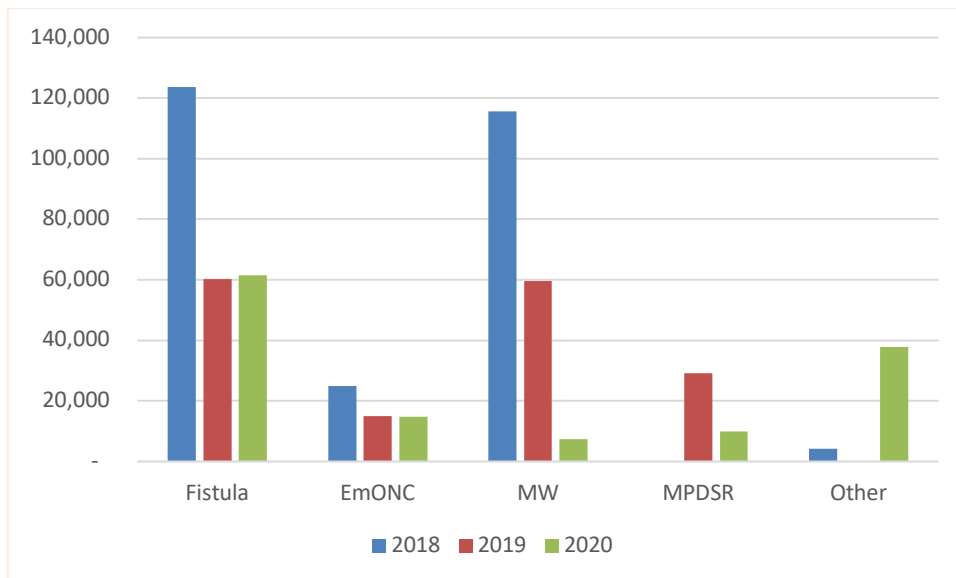
Figure 6 shows the distribution of resources across the four main technical areas of the MHTF in Uganda. Fistula (44 per cent) accounts for the greatest share of MHTF investments during the three-year period, followed by midwifery (32 per cent). “Other” expenditures cover funding for the “GetIn App” in 2018 (Section 3.6) and COVID-19 expenditures in 2020 (Section 3.9).

Figure 6: Total MHTF funding across the four MHTF technical focus areas (2018-2020)



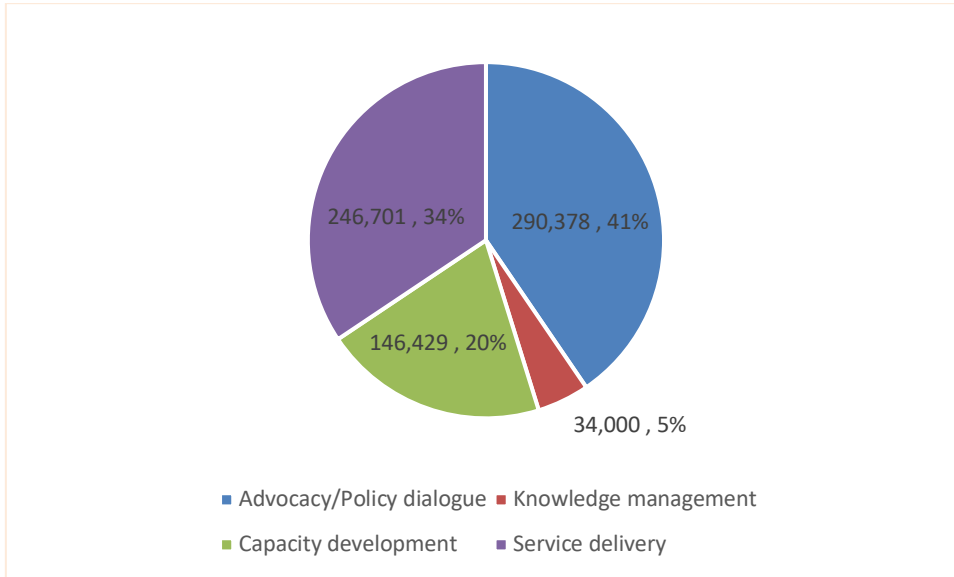
Distributed by year, expenditures for fistula and midwifery drop after 2018 to accommodate investment in MPDSR in 2019 and “other” investments (mainly for COVID-19 in 2020) in (Figure 7).

Figure 7: Disbursed MHTF funds across the four technical focus areas by year, 2018-2020



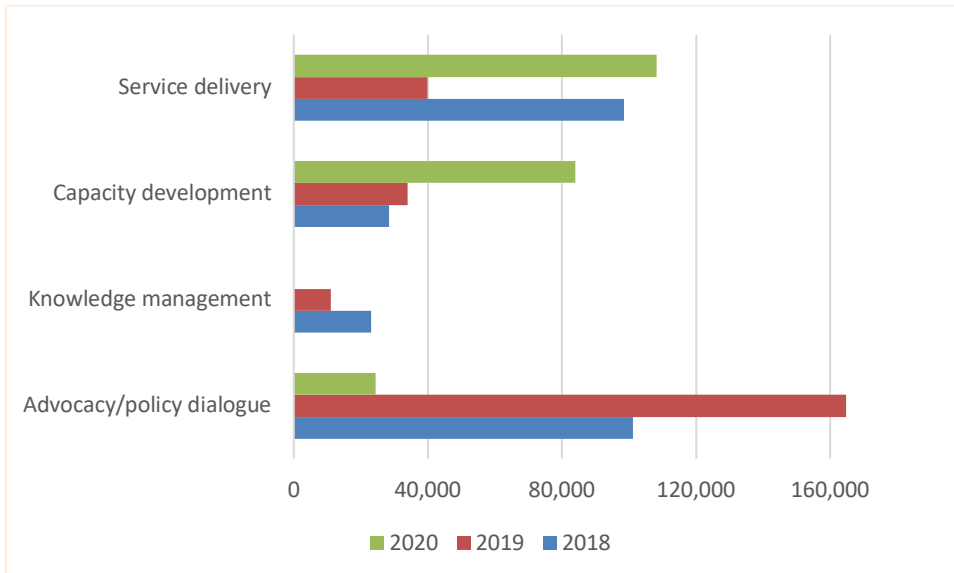
UNFPA delivers across five modes of engagement. These require different kinds of inputs and effort. While financial spending is not always a reflection of time, effort, importance or scale of result, it can be indicative of the focus of UNFPA work in the country. Figure 8 shows the distribution of total MHTF spending over three years suggests that advocacy and policy dialogue and service delivery are important to MHTF results in Uganda, followed by capacity development and knowledge management.

Figure 8: The cumulative distribution of investments across the modes of engagement, 2018-2020



Breaking this down by year highlights the way that programmes evolve and how UNFPA efforts are likely to shift year on year. For example, advocacy and policy dialogue was critical to the revitalization of MPDSR, accounting for the large share for this mode of engagement in 2019 (Section 3.3). The shift in funding towards service delivery in 2020 is reflective of the needs that emerged during the onset of the COVID-19 pandemic (Section 3.9)

Figure 9: The distribution of MHTF investments across the four modes of engagement, 2018-2020



Key coordination and implementing partners

Uganda is notable for a large and complex funding landscape of development assistance for health. The Global Fund has the largest health footprint in the country followed by the US Government (USD 43 million). Table 6 highlights some of the main development assistance partners for UNFPA that

include components that directly supported maternal health and/or complemented activities supported through MHTF resources during the period under review (2018-2020).

Table 6: Key development assistance partners for UNFPA maternal health activities in Uganda²¹

Development Partner	Description	Funding period
Swedish International Development Cooperation Agency (Sida)	Improving MNCH and adolescent health	2015-2018
Sida	UN Joint Programme on GBV (with UN Women)	2018-2023
Korean International Cooperation Agency	Prevention of teenage pregnancy and child marriage	2016-2018
Denmark	Women, adolescents and youth rights empowerment	2018-2022
The Netherlands	Advancing SRHR in West Nile and Acholi Sub-regions (ANSWER)	2019-2023
European Union	Spotlight initiative to eliminate violence against women and girls	2019-2020

CASE STUDY FINDINGS

Midwifery

UNFPA has made important contributions to midwifery in Uganda, as the sole development partner working with relevant ministries to advance an enabling environment for policy, education and deployment. Utilizing MHTF resources, UNFPA accomplishments are manifold and have contributed to an improved regulatory environment and strengthened education and training for midwives. The establishment of a Geographic Information System (GIS) has provided timely data use in planning and has helped to increase awareness of the workforce needs. Overall, UNFPA has successfully promoted midwives as an essential cadre for the advancement of SRH and MNH services, through its support to the National Midwives Association of Uganda (NMAU). It has used its relatively limited resources to effectively address a comprehensive set of programme components related to midwifery regulation, workforce, education, association and enabling environment as set forth in the global UNFPA and the International Confederation of Midwives (ICM) midwifery strategy. However, without a strategy for mainstreaming and sustaining these efforts, continued progress is at risk.

For details of the evidence supporting findings in Section 3.1, see Annex 1: Assumptions 1.1, 1.2 and 1.3

Strengthening the midwifery workforce

UNFPA in Uganda aims to improve the policy and work environment for midwives to ensure coverage and access to skilled birth attendance, with priority given to rural and underserved districts. This is seen as very important across the range of key informants interviewed, as no other agency is currently addressing midwifery in a strategic manner.

UNFPA works with several institutions responsible for overseeing the practice of midwifery in Uganda. These include the MoES, responsible for the pre-service education and training of midwives. Once trained, midwives are given exams by the Uganda Nurses and Midwives Examination Board (UNMEB); they are then required to register and obtain practicing licenses from the Uganda Nurses and Midwives Council (UNMC), which is overseen by the MoH. Once licensing has taken place, midwives are recruited in service by the health service commission at central level and district service

²¹ Source: UNFPA Evaluation of Uganda 8th Country Programme, 2020.

commissions at district level. In 2020, there were approximately 45,000 enrolled midwives and nurses in Uganda.

Developing the midwifery scope of practice

UNFPA is supporting the UNMC to develop the midwifery scope of practice as a means to ensure quality by reducing the number of births attended by unskilled practitioners. The scope of practice in Uganda, as defined in the Nursing and Midwifery Act, has not been updated since the mid-nineties; and it is no longer in compliance with the standards set by the ICM. Developing the scope of practice is critical to workforce strategies for “task-shifting” or optimizing the role of midwives to deliver cost-effective MNH services in areas where there are physician shortages. The implementation of task-shifting is seen as a pragmatic response to the health workforce shortage.

UNFPA began working with UNMC in 2018 to develop the scope of practice to enable midwives at bachelor level to perform advanced midwifery procedures, such as assisted deliveries using vacuum extraction to increase the availability and quality of EmONC services at lower-level health facilities. MHTF funding supported a consultancy to assist the MoH in the process to develop the national midwives’ scope of practice. This funding helped to “kick-start” the development, with co-funding from Foreign, Commonwealth and Development Office (FCDO) (UK) under the Rural Initiative for Community Empowerment (RISE) programme; however, recent cutbacks have stymied the effort. The scope of practice is currently under review by the Solicitor General to approve the legal aspects of the policy. Once this occurs, there will be a process for further stakeholder review, although the funding gap has not been addressed. Nevertheless, the UNMC has suggested that it will use its own resources to finalize the policy, indicating its alignment and ownership for the process.

Supporting workforce planning through GIS for midwives

In 2017, with funding from the MHTF and Sida, UNFPA supported UNMC to develop and roll out a GIS to provide timely data on all midwives and nurses that can be accessed and viewed across districts through an online platform. The GIS maps data on the cadres of midwives and nurses available, along with their licensure, registration, deployment and distribution. In addition, it tracks retirement and deaths of personnel. Prior to the GIS, mapping data was unavailable for planning. The national and district health services commissions are responsible for recruitment. When districts hire, the national level does not get information in real time.

“It was a big black box – we didn’t know how many were practicing, how many retired or died.” – NGO partner

MHTF funding supported the initial pilot of the GIS in 2018 in three districts (Gulu, Lawmo and Kitgum). The pilot involved orienting stakeholders at national and district level on the GIS as well as training midwives to upload data into the system. UNFPA also helped establish 13 regional registration centres within the regional referral hospitals (RRH) to enter and update midwives’ records, including students enrolling in midwifery training programmes. Data is input into the system on a daily basis and data is generated when needed for planning purposes. Government and non-government organization (NGO) key informants all noted the contribution made by UNFPA to establish a tracking system to generate the evidence required for needs-based planning for midwife training and deployment.

Through a combination of MHTF and Sida funding, the system has been rolled out to 40 districts as of 2020 although this is just a fraction of the total number of districts in Uganda (n=135). UNFPA also supported validation exercises to ensure the data entered was accurate. Unfortunately, resources are not available to support a national rollout to remaining districts and progress is slow towards full implementation of the GIS and its eventual institutionalization as a government-owned process.

Nevertheless, the early results have been impressive. Prior to the GIS, the time it took to process license renewals was three years and compliance with the renewal process was 35 per cent in 2014. Renewals have increased to 73 per cent at present. Further, the GIS has resulted in compliance with

registration, from 54 per cent in 2014 to 70 per cent in 2019, as well as increased revenue for the UNMC as a result of timely registration payments and license fees. An important outcome has been to reduce the number of illegal practitioners. A key informant noted that the implementation of GIS in Kitodo district resulted in the reduction of illegal practices and now it is one of the best performing districts. In the districts where the GIS has been rolled out, there is better collaboration between the midwives' association (NMAU), the nursing officer in the RRH works and the assistant district health officer with the assistant district health office (DHO) to track and register the nurses and midwives in their districts. One key informant suggested that the MoH technical working group (TWG) on human resources for health considers the GIS as the “de-facto system” for reporting nationally.

Strengthening midwifery clinical education and training

UNFPA has supported the quality of midwifery education through a variety of activities. UNFPA has supported MoES for the revision of the midwife curriculum in accordance with the ICM and WHO guidelines, shifting from a subject-based to a competency-based curriculum. This has contributed to improving the quality teaching and facilitated “easy testing and assessment of learning”, although it is too early to say whether it has improved the competencies of the students (implementation only started in 2019 and was paused due to COVID-19-related closure of schools).

“The curriculum guides very well – it is easier than before when the teachers were defining the assessment areas and it was not clear what they should or how to assess. The new curriculum shows clearly what a Year 1 student is supposed to know and able to do. It is also stated exactly what equipment, learning materials and human resources are needed for teaching this competency.” – MoES official

MHTF funding enabled UNFPA to support implementation of the Structured and Collaborative Clinical Training Programme (SCCTP), which consists of a six-day module to train preceptors. These are mentors, based in clinical areas in hospitals, who are responsible for supervising and teaching midwifery students and interns. The SCCTP is designed to improve competencies in clinical teaching and support a positive clinical learning environment for midwives. With support from MHTF, 90 preceptors linked to 30 EmONC training sites were trained between 2018 and 2020 contributing to the improved capacity of midwifery educators.

UNFPA also assisted the MoES to conduct facilitative supervision in 20 training institutions to identify gaps and develop action plans for follow-up (2018). As part of this effort UNFPA, with support from Sida, also provided equipment for skills laboratories at these training institutions. Such equipment includes models for student demonstrations and practice.

Improving access in hard-to-reach areas through midwifery scholarships

In order to address the need for skilled birth attendance in rural, underserved areas, UNFPA has provided long-standing support for over a decade for training and sponsoring midwifery students under a bonding scheme. This helps to address the difficulty districts have to attract recruits to work in rural areas. Even when the district has the funds available to hire staff, graduates tend to want urban posts. To address this issue, UNFPA has implemented a sponsorship programme which recruits girls from underserved communities within the district and supports them with scholarships to cover tuition payments and books, in exchange for a two-year bonding to serve their respective area. The benefits are seen as two-fold, as it provides opportunities to marginalized girls and helps to address inequitable access to safe maternity services.

Since 2009, 615 girls have been trained under the bonding scheme, developed in response to a midwifery gap analysis conducted with MHTF resources. The scale of the bonding programme is not large; in 2020, 25 students were enrolled but did not start during the closure of schools due to the COVID-19 pandemic. Key informants noted that the results are visible when visiting hard-to-reach districts, such as Karamoja and Agago. However, a clear transition from UNFPA to the government is needed for this programme in order for it to be sustained and scaled.

Strengthening capacity and professionalization of midwives

UNFPA supported the creation of the NMAU in 2018 with MHTF funding to provide professional support for midwives working in the public, private and non-profit sectors. Prior to this, there was one association for private midwives only, the Uganda Private Midwives Association (UPMA). USAID has provided significant levels support to UPMA through various projects to support private midwives in their professional development, mentoring and networking opportunities. UNFPA has provided support to UPMA, but this was focused more on discrete activities rather than on organizational capacity-building. For example, in 2018 UNFPA provided funds and equipment to UPMA to conduct family planning training in Soroti district and to conduct mentorship for midwives who had been provided midwifery kits from UNFPA in Northern Uganda.

NMAU provides a platform for midwives to advocate, participate in health policy matters, grow in knowledge and skills, and network and collaborate. UNFPA supported NMAU to develop its first costed strategic plan which was finalized in 2020. UNFPA supported a consultant to lead the development of the strategy and support a process for obtaining input on the inception phase from a multi-sectoral committee of the MoH to ensure buy-in and political support from national key stakeholders. The plan has been finalized and is on track for dissemination in 2021. Further, this plan has laid a foundation for Sida funding of NMAU and its midwife-led activities to increase awareness of midwifery services at community level, including inspiring girls in school to choose midwifery as their career of choice. In 2020, NMAU boasted over 300 members.

MHTF funds also supported annual commemorations of the International Day of the Midwife (IDM), held on 5 May each year and linked to a global initiative of the ICM, a UNFPA partner under MHTF. The purpose of the IDM is to bring awareness to the important role midwives play in ending preventable maternal and newborn deaths and achieving Sustainable Development Goal (SDG) 3.1. ICM provides global guidance through advocacy tool kits for the annual IDM, including important data and information for use in designing the commemoration at the country level. The UNFPA country offices are encouraged to hold these commemorations annually, and they represent a significant level of effort within the MHTF portfolio in what one key informant described as “more political than programmatic” in nature.

The IDMs supported during the period of this evaluation were organized around different themes: “Midwives leading the way with quality of care” (2018), “Midwives, defenders of human rights” (2019), and “Midwives with women: Celebrate, demonstrate, mobilize, unite – our time is now!” (2020.) IDM commemorations are often done in conjunction with a midwifery symposium, which provides midwives an opportunity to network and exchange knowledge through presentations and exhibitions by partners to share policy and technical briefs on good practices, innovation, and information, education and communication (IEC) materials. Pre-event activities included press releases, radio talk shows and community mobilization in the event a reproductive health outreach is conducted as part of the event.

For example, the 2018 IDM activities (held in Jinja district) included midwife-led blood drives and career promotion, provision of reproductive health services via outreaches (family planning, antenatal care (ANC), PHC, HIV screening and testing, immunizations and cervical cancer screening), radio talk shows, community mobilization through schools and a film van, advocacy meetings with host district leaders, a midwives’ symposium (with 18 partner exhibits), and the placement of midwifery stories in the media. The IDM was attended by the Speaker of Parliament and the Ambassador of Sweden. In 2020, due to the COVID-19 pandemic, the IDM was held virtually with minimal physical attendance at the Mulago Specialized Women and Neonatal Hospital. To mark the day, UNFPA held a press conference and supported the placement of many media stories on midwives in a variety of social and other web-based outlets to promote the important role midwives play in providing essential

care. An important result of the IDMs is recruitment of new midwives for the NMAU. In 2020, an additional 72 midwives were recruited, bringing the total number of members to 326.

UNFPA has adhered to the current global MHTF strategy for midwifery (2018-2021) that sets forth a holistic approach to ensure equitable access to quality midwifery services and care through implementation of five key components: regulation, education, association, workforce and enabling environment. With relatively limited resources, UNFPA has supported each of these components in Uganda which has resulted in greater awareness and attention among stakeholders regarding the importance of this cadre for achieving national maternal health goals. These gains are dependent on continued external assistance as there is no evident strategy for sustainability planning.

Emergency obstetric and newborn care network

Through MHTF, UNFPA contributed to improving the quality of EmONC services, building on an assessment conducted at the end of Phase II of MHTF to inform an update of the *National Quality Improvement Framework and Strategy* and related quality improvement (QI) training packages. Beyond this work at national level, UNFPA supported EmONC through the entry points related to midwifery and MPDSR, mainly by training midwives and funding district health officials to conduct supportive supervision and mentorship in UNFPA target districts. The focus on clinical quality of care does not directly or adequately address community-level issues that contribute to poor maternal health outcomes. While UNFPA has contributed to increased awareness and understanding of gaps in quality of care issues related to EmONC services, it has not undertaken a concomitant response to address them systematically and at scale.

For details of the evidence supporting findings in Section 3.2, see Annex 1: Assumptions 2.1, 2.2 and 2.3

Approaching EmONC through midwifery and MPDSR entry points

MHTF efforts in EmONC are approached programmatically through entry points related to midwifery and MPDSR (refer to Sections 3.1 and 3.3, respectively). The assumption gleaned from MHTF reports and interviews is that UNFPA work to advance EmONC in Uganda is embedded in broader SRHR policy and programme efforts, such as in the humanitarian response to train partners in the Minimum Initial Service Package (MISP) for SRH and clinical care prevention and management of GBV survivors, the new Sida joint GBV programme, and the Netherlands-supported programme to advance SRHR in West Nile and Acholi sub-regions. UNFPA did not report specific activities or interventions related to EmONC, with some exceptions related to support for quality improvement approaches and to address needs during COVID-19 (for the latter, refer to Section 3.9).

This is a departure from the approach, advocated by MHTF globally and in the business plan, to utilize a data-driven approach to support a network of limited facilities on which to better focus resources to ensure universal coverage. Uganda country office staff were unfamiliar with the network approach, nor was there a clearly articulated approach that was pursued to advance EmONC in its stead.

Assessing quality of care issues in EmONC services at national and sub-national level

Prior to the start of MHTF Phase III, UNFPA and MoH assessed EmONC services in 25 districts in the Western, Eastern, Northern, Karamoja and West Nile regions of Uganda. The assessment identified a range of bottlenecks to achieving coverage of high impact MNH interventions at scale. The assessment indicated that in surveyed facilities in these districts, the overall met need for EmONC in 2017 amounted to 1.5 per cent. (The recommended goal is 100 per cent met need for 15 per cent of births.)

The bottlenecks identified included the limited availability of skilled birth attendants, equipment, supplies needed to address emergencies during labour and delivery. In addition, the functioning of

the referral system between HC IV and lower-level facilities was affected by non-functioning ambulances and communication difficulties. Even when health providers were available and performing required tasks, quality of care was poor. For example, partograph use to monitor women in labour was high, but done without adherence to standards.

The assessment found that only 71 per cent of HC VI (CEmONC sites) perform caesarean sections due to lack of skills (in particular, anaesthetic officers) and/or infrastructure or equipment. In the national standards for EmONC, “assisted delivery” is a key signal function, including at HC III facilities (i.e., BEmONC sites). But the health worker (midwife) at HC III is not yet mandated by their scope of practice to do assisted delivery, nor is assisted vaginal delivery part of the midwifery pre-service curriculum. Therefore, in any HC III (BEmONC site), they can only perform 6 out of the 7 basic signal functions, unless a medical officer is available. UNFPA efforts to address the scope of practice policy is intended to remediate this problem.

Interviews with MoH and service providers mirrored the results of the 2017 EmONC assessment. Key informants note that UNFPA works to address challenges related to the supply side of care, notably ambulances and referral systems, availability of skilled birth attendants, and supply chain management. These challenges relate to the second and third delays in pregnancy complications, i.e., (delays in referral to an appropriate facility and delays within the facility to receive appropriate care, respectively), rather than on the first delay (recognition of the need to seek care). However, MoH and other stakeholders note that there are major issues and gaps influencing MNH in Uganda. These are related to demand and health-seeking behaviours at the community level (such as preference for traditional birth attendants) and perceptions about poor quality of care at health facilities, including lack of medicines (or having to pay for them out of pocket), disrespectful treatment, lack of staff and therefore treatment, etc.

While UNFPA has contributed to increased awareness and understanding of gaps in quality of care issues related to EmONC services, it has not undertaken a concomitant response to address them systematically and at scale.

MHTF support for EmONC is limited in scope to quality improvement

UNFPA undertook several efforts at the national level to advance quality in SRH and MNH service delivery with MHTF support. For example, UNFPA supported the revision of the *National Quality Improvement Framework and Strategy 2020- 2025* and the finalization and launch of the Patient’s charter on the World Patient’s Safety Day commemoration. UNFPA also supported MoH to update the quality improvement (QI) training packages and train 50 national and regional trainers to conduct supportive supervision. These national level documents are important to set the expectations and standards for QI throughout the country.

Aligned with these standards, MHTF resources supported the mentoring of midwives in the provision of quality EmONC services, including the rollout of the quality of care standards in 20 facilities in 10 UNFPA target districts. Under the ANSWER programme, UNFPA is strengthening supportive supervision conducted by DHOs on a quarterly basis. This includes the conduct of a joint clinical quality audit which check service delivery against clinical guidelines and standards. A competency assessment for midwives was conducted to assess level of knowledge and skills in EmONC and to guide training and mentorship plans in 2020. Two senior district health care providers are selected to become lead mentors; they receive training, followed by on-site mentorship by trainers who are national MoH trainers/mentors. This cascade approach is intended to help the providers continue mentorship once the project is done (although it is often budgetary issues that limit sustained mentorship).

MHTF also funded targeted support for a consultant to provide technical assistance to the Kawempe national referral hospital (NRH) to develop a QI plan for the neonatal intensive care unit (NICU). NRH-Kawempe is a tertiary hospital in Kampala that serves a population of 4.5 million and performs 30,000 deliveries annually. The consultant conducted a quality assessment of NICU services, oriented

staff on protocols and management guidelines for common conditions, developed a QI plan, and assisted the NICU team to reorganize services. While this support was well-received, key informants note that NRH-Kawempe continues to have high burden of referrals from lower-level facilities while struggling with human resource shortages, including lack of midwives and anaesthetists. One of the contributing factors to health worker shortages are the staffing norms, which were developed 20 years ago before the Ugandan population tripled. A process is underway to update these norms.

UNFPA has utilised MHTF resources to ensure that quality improvement is embedded in national strategy documents and within the programme interventions it supports in targeted institutions and districts. The focus on quality of care is necessary, but not sufficient, to address the range of structural issues impeding access to EmONC services. Moreover, it is not evident the extent to which actions taken by UNFPA have influenced quality of care, generally, or EmONC services, specifically, beyond its sphere of influence.

Maternal and perinatal death surveillance and response

UNFPA has been a main contributor to the operationalization of MPDSR in Uganda with MHTF investments. A key contribution has been to support the MoH to hold **functional**, weekly meetings as a platform for collective review, problem-solving and resource allocation to address key causes of maternal and newborn deaths. UNFPA has supported the annual compilation, validation and dissemination of the MPDSR report; this has been credited with ensuring the continuing engagement and commitment of top MoH officials in the process and catalysing the support of other development partners. Key actions taken resulting from MPDSR deliberations include the creation of the national Postpartum Haemorrhage (PPH) Action Framework, which has improved the availability of blood through blood banks. While MPDSR activities have resulted in improved notifications and mortality reviews, follow-up actions to address findings are hampered because of lack of resources and wherewithal to follow-through at district and facility levels. Further, MPDSR is dependent on partner resources, whether in UNFPA target districts or supported by others such as UNICEF and USAID, affecting the extent of national scale-up and sustainability.

For details of the evidence supporting findings in Section 3.3, see Annex 1: Assumptions 3.1, 3.2 and 3.3

UNFPA supported revitalization of MPDSR processes at national and sub-national levels

In 2008, the President of Uganda declared maternal mortality to be a national emergency due to slow progress in bringing down the rate of maternal deaths. Thereafter, the MoH required all hospitals to routinely report and review all maternal and perinatal deaths to the national level through standard reporting tools. Based on lessons learned and the issuance of updated global guidance from WHO (2013), the MoH developed guidelines in 2017 to strengthen MPDSR processes at all levels in the health system. UNFPA (via the MHTF), WHO, USAID and others provided financial assistance to support the guidelines process.

Since 2017, UNFPA has helped the MoH to operationalize the implementation of the MPDSR guidelines in a variety of ways. A key priority has been to support the annual compilation, validation and dissemination of the annual MPDSR reports to ensure continued commitment and attention to the process. Previously, data was compiled on an *ad hoc* basis. UNFPA has been credited with helping to gain and sustain the continued interest of the MoH and other partners through the generation of evidence about the causes of maternal and perinatal deaths. Once reports are issued (with UNFPA assistance) on an annual basis, the tide turned and commitment among the MoH and its partners was enhanced. In 2018, the annual compilation was supported by UNFPA alone, with other partners providing technical support (but not funding). In 2019, other partners (USAID, UNICEF) supported expanded dissemination of the report demonstrating the catalytic effect of MHTF.

At national level, UNFPA supported the national MPDSR Committee to routine meetings and confidential inquiries at regional level. UNFPA supported and participated in weekly meetings of the

committee held to focus on MPDSR at two national facilities, NRH-Kawempe and Mulago Women's and Neonatal Specialized hospitals. These meetings have helped to spur action and strengthen the response to maternal and perinatal death reporting through confidential inquiries. For example, MHTF funding enabled a specialist team to visit lower-level facilities to better understand root causes of the high number of referrals to NRH-Kawempe. UNFPA has also helped to address gaps identified by mobilizing resources from MTN-Uganda (telecommunications network provider) to address equipment and renovation needs. MHTF support to improve the functioning of the NICU at NRH-Kawempe has been observed to reduce neonatal deaths at the facility.

A major achievement is the continued commitment of top leadership of MoH to participate in weekly MPDSR meetings and its use as a platform for collective problem solving and resource allocation.

“With UNFPA support we are able to analyse the data every week, take action every week, and follow-up on the actions. Initially, we were at a quarterly level for MPDSR meetings, but now they are weekly.” – MoH official

The creation of the national PPH Action Framework, developed to address the high percentage of maternal deaths due to PPH and the weak blood supply chain system, is an important result of the weekly MPDSR meetings. High level engagement of national MoH and other stakeholders in MPDSR is seen to have resulted in improvements in the availability of blood through blood banks. The PPH Action Framework was launched at a meeting disseminating the 2019-20 MPDSR Annual Report. UNFPA is now assisting the MoH to revise the list of life-saving drugs to include heat stable uterotonics on the Essential Medicines List. In addition, UNFPA and WHO are supporting the MoH to conduct operational research to test heat stable drugs for PPH management in West Nile region.

Stakeholders indicated that the revitalized attention at the national level has resulted in increased motivation by health workers at referral sites to continue the work of mortality reviews. The weekly platform at the national level is chaired by the Assistant Commissioner for Reproductive and Infant Health and includes representatives from academia, RRHs, DHOs, assistant district health officers (in-charge of maternal health), United Nations agencies (WHO, UNFPA, UNICEF), USAID, civil society organizations, and other implementing partners. When deaths are reviewed, the group identifies common issues and then works with partners to reach out to facilities. Paying attention to reporting and working to solve issues contributes to a virtuous cycle of reporting. Throughout interviews, there was the consistent theme among stakeholders that MPDSR is part of the quality improvement cycle and a learning process.

“There is a lot of attitude change at facility level regarding these reviews. In the beginning there was more punitive action and blaming the health facilities, so health workers withdrew. In 2016-2017, they would not review, not report, for cause of fear. They would not report the deaths. Making the whole thing being on the head of the health workers, discouraged them. It is changing now, although we still have cases where they are hesitant to report death and review, there has generally been a positive change over time. Also, whenever we publish the reports, implementing partners and others support the process. The National level also does “confidential inquiries” – they are not just information picking – but also support capacity building.” – UNFPA staff

Notifications and reviews are improving, but not close to reaching national targets

There has been an increasing trend in the notifications of maternal deaths. In 2017-2018, 1,100 maternal deaths were recorded in HMIS; of these approximately one-half (49 per cent) were notified and 47.5 per cent were reviewed. This represents an increase from 2016-2017 when 27 per cent were notified and 27 per cent were reviewed. Notifications increased at a rate of 58.5 per cent over the next year, although it still falls short of the national HSDP target of 85 per cent. Stakeholders credit this improvement to the revitalization and formation of MPDSR committees and training of health workers and HMIS officers. However, MPDSR receives greater priority and attention in

districts where development partners (UNFPA, UNICEF and USAID) are active and funding efforts and has yet to be scaled nationally to all geographic regions.

Reports indicate that the number of reviews has also improved since 2018. In 2018, reasons cited to explain the low proportion of deaths reviewed included: poor records management (especially at lower-level facilities); stock-outs of MPDSR tools; lack of staff capacity to analyse causes of death; and non-functional MPDSR committees. The MoH reported that maternal death notifications and reviews saw their greatest improvement between 2018-2019 and 2019-2020. This came as the result of a range of interventions undertaken, for example: training and mentoring of health workers on documentation and timely reporting; printing, distribution and orientation on revised MPDSR tools; targeted data quality assessments; and the decentralization of entry of notifications and review reports at facility and district level (as opposed to central level). Further, results-based financing (in districts where this is supported), contributed to incentivizing the MPDSR committees in districts. A recent evaluation²² found that there was increased awareness among stakeholders regarding the use of MPDSR as a quality improvement tool. However, the functionality of the MPDSR committees at district and facility level remains an issue despite the aforementioned efforts to address problems.

In one district visited (Gulu), the notification and review process is performed by the DHO team with facility teams with a view to identifying the root cause of the death that occurred at the facility. A major challenge, however, rests in obtaining funds to invite staff from lower-level facilities to participate in a review of a death that occurred at a higher-level facility. The process works as follows: an internal audit is performed at the facility; notification of the death to the district is done within seven days; then, the district health team visits and reviews the death with the facility staff, community representatives, the health unit management committee (HUMC). UNFPA assisted with training of DHO and HUMC and a UNFPA staff joins the district in its quarterly reviews.

Follow-up of findings and action points from reviews remain a critical challenge

In UNFPA-supported districts, UNFPA facilitates follow-up of recommended actions identified by DHOs via the MPDSR process. In districts where UNFPA supports programmes to advance SRH-MNH services, UNFPA has provided financial assistance to DHOs and facilities to conduct MPDSR meetings as well as support follow-up to address action points. DHOs have a budget for follow-up visits through PHC grants. However, these are often insufficient to support transport and funds for daily subsistence allowance for quality improvement and MPDSR follow-up. UNFPA has stepped in to facilitate follow-up and facility-based mentoring through funding for travel from districts to facilities when funds are available; however, when resources are not provided, follow-up falls by the wayside and recommendations are less likely to be implemented.

There remains the issue of the quality of recommendations, follow-up and implementation at all levels of the healthcare system. Action points from facility level reviews are often not implemented, which results in the demotivation of staff to conduct further reviews. Often the districts do not have funding to implement recommendations (such as resources required to travel for additional EmONC training and mentorship.) However, many of the recommendations are beyond the capacity of the facility and require system-wide attention. For example, the referral system needs improvement in terms of timeliness; availability of logistics (such as ambulances and their readiness to transport mothers); inter-facility communication; and pre-referral management. Also shortage of essential MNH medicines occurs across all levels of health facilities. Finally, while stakeholders recognize that the delay to seek care (the first delay) is the most avoidable factor contributing to maternal deaths, exacerbated by inadequate information regarding birth preparedness, lack of partner support, and lack of transport, especially for young mothers. Interventions to address these problems requires action beyond the facility and not all districts or their partners are well-positioned to implement them.

²² GoU and UNFPA, UNFPA 8th Country Programme 2016-2020 Evaluation Report, 2020.

Fistula and other obstetric morbidities

UNFPA has been the main partner of the MoH on fistula and has provided strategic leadership for more than a decade in Uganda. A major contribution was the review and costing of the national fistula strategy, which calls for a shift in service modality from camps to routine services. UNFPA has also enhanced coordination through its support for the fistula TWG as well as increased awareness of fistula through the annual commemoration of the International Day to End Obstetric Fistula. MHTF resources for fistula have been channelled primarily to increase capacity at national and regional levels for fistula repair, which are mainly done through occasional camps and remain highly donor dependent. Prevention is supported by UNFPA through other activities, such as EmONC, family planning and women and girls' empowerment; however, these are not intentionally programmed nor tracked in a meaningful way to ensure that linkages are strong and effective. UNFPA has recently moved into reintegration work; this remains largely the purview of NGO partners with the public sector lacking capacity to offer the panel of (social, medical, psychological, economic) services to help fistula survivors settle back in their community.

For details of the evidence supporting findings in Section 3.4, see Annex 1: Assumptions 4.1 and 4.2

With the MHTF, UNFPA aims to support countries to take steps to prevent and respond to fistula and similar conditions to reduce maternal emergencies, save the lives of newborns, and improve quality and availability of care. Fistula incidence reflects a range of factors, the extent of primary prevention measures in place (family planning, women and girls' empowerment), as well as the proximity and use of EmONC and referral capacity for more advanced care. Per MoH estimates, annual incidence of fistula in Uganda is 1,900 cases. A recent study estimated that lifetime prevalence of vaginal fistula symptoms, between 16.3–22.5 per 1000 women of reproductive age 15–49, putting Uganda highest among African countries.

“In Uganda, women with fistula are living indicators of failed maternal and child health systems. The number of women suffering from obstetric fistula in Uganda is estimated at 1% of women of reproductive age (UDHS 2016), translating to range about 75,000- 120,000 women with the problem.”– UNFPA Uganda

Leading the way through national coordination and strategy development

UNFPA is considered the main partner for MoH on fistula and has provided leadership on strategy development for more than a decade. UNFPA supported the first national fistula strategy in 2010. More recently, with MHTF resources, UNFPA supported the process to revise, review and approve the costed Obstetric Fistula Strategy 2021-2024/25. This latest strategy aligns with national and international policies and strategy documents, including the HSDP and Vision 2040 and the SDGs.

UNFPA supported the MoH to lead the development of the revised strategy, incorporating technical inputs from many partners through the national fistula TWG, including WHO, UNICEF, USAID, AMREF²³ and Medical Teams International (MTI). This new strategy aims to strengthen the integration of fistula repair as a routine service and practice at the national, regional and selected general hospitals across the country, shifting from the camp-based mode of repair and treatment.

“UNFPA was captain in the area of fistula – because they supported the national fistula strategy and its the revision. The new strategy gives more focus on shift from camp-based repairs to more facility based routine repairs. Of course, that is quite a big dream.” - MoH official

²³ AMREF is an Africa-based healthcare non-profit that provides mobile and clinic health services to Africa and trains physicians and other health care workers to deliver PHC.

As part of its work to strengthen the MoH leadership, UNFPA has utilized MHTF funding to support the ongoing work of the national fistula TWG to meet regularly to provide policy oversight and coordinate fistula activities throughout Uganda. UNFPA has helped to enhance the function and operations of the fistula TWG through the development of terms of reference for the work of the group and support for routine quarterly meetings. The overall goal of the fistula TWG is to ensure harmonized work towards achieving the goals and framework of the National Obstetric Fistula Strategy. It meets every three months to review policy proposals, fistula components for sector policy and strategic documents, as well as the MoH annual workplans and budgets. The TWG also coordinates state and non-state actors engaged and aligned with the strategy and works towards increased mobilization and leveraging of resources to ensure coverage of fistula care.

The fistula TWG is an important forum for mapping out who is doing what across the country in fistula so as to avoid duplication of efforts and to understand gaps that require additional resources. In 2020, UNFPA supported the TWG to develop and approve a set of National Fistula management HMIS documentation and reporting tools, such as the obstetrics/gynaecology (OB/Gyn) and fistula theatre register, fistula care register, treatment and follow-up register and a registration form for documenting clinical notes and monitoring of care. Working with AMREF, UNFPA supported printing of fistula registers data quality assessment and validation in at least seven selected districts to improve the quality of data.

Capacity-building for fistula treatment through camps

The main use of MHTF resources earmarked for capacity-building in fistula has been to support treatment, mainly through camps conducted in conjunction with surgical teams from NRHs and RRHs. Over the years, capacity has been built at the national level to perform fistula repairs and to train and mentor other surgeons. In 2020, over 1,400 women were treated, 60 per cent were directly supported by UNFPA through 18 fistula repair camps by 14 facilities (1 NRH, 9 RRHs and 4, private, not-for-profit or general hospitals). Fewer camps were held in 2020 due to COVID-19; UNFPA estimates that 3,000 repairs are needed in 2022 to reduce the backlog further.

UNFPA complemented MHTF resources with funds from other programmes to support fistula repairs, i.e., Sida Joint Programme on GBV and EU-Spotlight Initiative. Fistula treatment is not yet considered by the Ugandan health system as part of the routine package of services, nor is it adequately funded through government. Although there is a call to shift service delivery from camps to routine services, camps are still the dominant mode of service delivery for fistula repairs, and it remains highly donor dependent. USAID used to be the main donor for fistula through its Fistula Care Project, especially for camps and outreach; however, this shifted in 2018 when support was phased out. A UNFPA informant described fistula as an “orphan” technical area, as donors tend to provide time-limited funding. Therefore, UNFPA support for fistula camps is deemed by stakeholders to fill a critical gap for the vulnerable women suffering from this condition.

Interviews with service providers outline some of the challenges in transitioning from camps to a routine model. This requires equipment and space, as well as a team dedicated to fistula and present to perform the operations. Most indicated that an available operating theatre, while not “a must,” would be extremely helpful in busy, overburdened NRH or RRHs. A dedicated theatre would, indeed, enable repairs to happen without disrupting other essential, emergency services.

Camps are organized to engage expert trainers in fistula repair from NRH or RRHs to visit a general hospital where clients have been mobilized in advance to receive the services. Funding for camps covers awareness creation, transportation of the women to the hospital, feeding during hospital stay, materials and commodities, and the travel allowances for the fistula surgeons coming from other places. The advantages of providing services via camps are that they offer opportunities to train surgeons while also increasing awareness of providers from the host facility about fistula prevention and safe surgical practices to address growing anecdotal evidence of iatrogenic fistula from poorly done caesarean sections.

Camps also support increased awareness of communities of fistula as a result of efforts to identify women needing repairs, reduce stigma among women with fistula, and promote prevention strategies. Identification of women who need fistula repairs is usually through mouth-to-mouth – women who come back from fistula camps and have been successfully repaired, tell other women about the possibility for repair. Health facilities also refer women with fistula to different camp sites. Awareness and demand creation is also through national and local radio, facility health talks, community-outreach, and mouth-to-mouth.

With respect to fistula prevention, UNFPA contributes to this area mainly through its safe motherhood activities to strengthen midwifery and skilled birth attendance (Section 3.1) and the delivery of quality EmONC services (Section 3.2). In addition, prevention is also addressed through non-MHTF-supported programmes that address adolescent SRHR, gender and family planning.

Increasing awareness of fistula at community and national level through International Day to End Obstetric Fistula commemorations

Each year, UNFPA utilizes MHTF funding to hold events to raise awareness about the causes, complications, prevention and treatment of obstetric fistula while advocating for support and to strengthen health partnerships at all levels. The International Day to Eliminate Obstetric Fistula (IDEOF) commemorations are conducted in conjunction with the Global Campaign to end fistula, a platform for over 90 partner organizations around the world committed to increasing investments and efforts to eliminate fistula worldwide by 2030. As the main convener of the partnership, UNFPA encourages its country offices to participate as a means to increase awareness among key actors to mobilize resources and support initiatives related to fistula.

UNFPA organized annual IDEOF commemorations in partnership with the MoH to occur at the same time as a fistula camp. The campaign is organized around a different theme each year; for example, “End fistula now: Reach everyone” (2018), “Fistula is a human rights violation – end it now” (2019), and “End gender and health inequalities – end fistula now” (2020). In 2020, UNFPA estimated the campaign reached 500,000 Ugandans through a variety of media, such as social media posts, live webcasts, radio advertisements and talk shows, spot advertisements on TV, community sensitization film vans and loudspeakers, printing and distribution of IEC materials and newspaper supplements.

The campaigns are well-received by stakeholders, however, as with the IDMs (Section 3.1), there are not any measures to determine the resulting outputs and outcomes. However, because the campaigns are conducted in conjunction with fistula repair camps, stakeholders say that they help with the identification of fistula clients in the community and contribute to decreasing stigma regarding the condition.

Expanding beyond prevention and repair to rehabilitation is just beginning

“Reintegration refers to a deliberate approach during which fistula survivors or those with fistula deemed incurable are given social, psychological, medical and economic support to enable them to settle back into the community. - MoH Fistula Reintegration Services at Facility and Community Levels, 2019

In 2019, UNFPA supported an assessment of fistula reintegration services in Uganda to guide future efforts and strategic advocacy to promote implementation of reintegration efforts. The reintegration assessment found that only one in five providers engaged in fistula had received any training in reintegration. Reintegration efforts are mainly found in private, not-for-profit facilities, as government facilities do not have the capacity to support such services. UNFPA supported the MoH to develop a minimum health care package for reintegration of women with fistula, guided by WHO reintegration principles. The package outlines services to be offered at a facility and in the community, with an emphasis on linkages between the two levels.

“It was important to develop a standard package, and review this package with MoH, to ensure when we talk about reintegration, we understand the same thing. Reviewing this

package, what it entails, what it costs – will be a focus in 2021. It will also be a very good resource mobilization – if you have 50 women, how much will it cost to reintegrate them – it will be important and useful when we lobby for funds with our donors.” – UNFPA staff member

UNFPA has provided support for approximately 10 years to the Association for the Rehabilitation and Re-orientation of Women for Development (Terrewode), headquartered in Soroti, Eastern Uganda. Terrewode is a leading civil society organization working on fistula for the past two decades. Terrewode uses a holistic approach to address the issues of obstetric fistula, which has been developed over time and is based on the experiences and lessons learned. It has a strong focus on the community engagement to empower and educate young women in rural communities. Terrewode has been a leading voice in Uganda about the vulnerability of women with fistula and the need to ensure their rights and restore their dignity by connecting them with holistic services, including reintegration.

UNFPA funding for Terrewode was channelled through the MoH for both camps and reintegration activities. Terrewode has established a dedicated women’s community hospital that offers specialized, routine fistula surgeries, and is an important site for teaching and learning. It also has a community outreach arm that collaborates with health facilities and other partners to support community awareness, treatment and reintegration. It also addresses root causes, such as teenage pregnancies. Terrewode is an important partner for UNFPA and the MoH regarding the development of costed models for establishing fistula care, as a routine service that also include reintegration.

SRHR and MNH integration

In a programme context with many players and scarce resources, UNFPA considers integration its main comparative advantage in Uganda. UNFPA is recognized by partners as an important convener and provider of support to the MoH for matters related to SRHR-HIV-GBV integration and is seen as bringing valuable expertise to the table in policy dialogue and deliberations, such as for the revision of the RMNCAH investment case. UNFPA has worked to advance models of integrated SRH-MNH services in its targeted districts through a patchwork of resources from its portfolio of diverse programmes dealing with the advancement of SRHR, adolescent health and gender equality and women’s empowerment. However, lack of an identifiable MHTF strategy to guide integration results in missed opportunities to strengthen linkages across the patchwork of different donor-funded activities or to mitigate the structural and socio-cultural challenges of the health system that affect effective implementation of integration.

For details of the evidence supporting findings in Section 3.5, see Annex 1: Assumptions 5.1, 5.2 and 5.3 and Assumption 8.3

Integrated programming: a necessary strategy to reach goals in the context of limited resources

UNFPA considers integration its main comparative advantage in a funding landscape that has many players and scarce resources. This is especially true for MNH interventions, where UNFPA is a “small contributor” yet committed to achieving universal access to SRHR and the three “zeroes” in the strategic plan (maternal deaths, unmet need in family planning and harmful practices). In the words of one key informant, the only way to do this is to “integrate, integrate, integrate.”

UNFPA supports integration through its participation in the maternal and child health (MCH) Cluster, an important MoH coordinating platform that includes several key TWGs, i.e., on commodities, family planning, adolescent health, continuous quality improvement (CQI), integration, etc. The MCH cluster is the group that coordinates the development and review of policies. Through this platform, UNFPA contributed to a range of important policies that advanced integrated approaches. This included the National Policy for Sexual and Reproductive Health and Rights and an Adolescent Health (ADH) policy, both of which are pending government approval. To support the “fast-tracking” of

evidence-based approaches to address SRH challenges faced by young-people, UNFPA supported the MoH to establish a high-level “ADH Think Tank” comprised of officials including the Permanent Secretary and Director General along with national ADH experts, multisectoral representatives and youth representatives.

UNFPA also advocated and supported the MoH through the MCH Cluster and commodity TWG to develop a national CQI framework with support from the MHTF. The new guidance includes tools related to post-abortion care (PAC) and postpartum family planning (PPFP), to ensure that quality improvement efforts pay attention to family planning in facilities offering maternity services. During the past two years, UNFPA also supported data management tools for integration in the national HMIS system. It is not yet possible to track integration of family planning within ANC, PAC and immunization services in Uganda.

UNFPA is recognized by partners as an important convener and provider of support to the MoH for matters related to SRHR-HIV-GBV integration in Uganda. UNFPA is also seen as bringing strengths to the table regarding its support of the MoH role in integration through the development of guidelines and the revision of the RMNCH investment case.

“I can clearly see UNFPA as a convening partner, bringing together several stakeholders from different institutions. It is impressive how they brought together all those stakeholders, commissioners, ministries for integrated SRHR, GBV and HIV. To get that commitment of government, to actually show up, and to make commitments; it was a good thing they did, and quite impressive and a key achievement. UNFPA has established itself as a key institution on SRHR, talking about adolescents, family planning, etc. When you talk with them about those topics, you immediately see a strength here.” – A development partner

On the other hand, some stakeholders noted that there are challenges to implementing a comprehensive package of integrated SRH-MNH services at the sub-national level, including UNFPA capacity to coordinate multiple implementing partners with different technical components and agendas. Some activities remain “vertical,” such as UNFPA advocacy for a costed implementation plan for family planning when the government wants an integrated costed implementation plan across the RMNCAH continuum of care. Family planning, in particular, remains underemphasized in the MHTF agenda, perhaps fuelled by an assumption that is being done by midwives.

Advancing models of integrated service delivery through a patchwork of different programmes

UNFPA has within its portfolio a range of programmes to advance SRH, adolescent health, and gender equality and women’s empowerment at national and district levels, including in humanitarian settings. For example, UNFPA conducted different exercises in 2019 and 2020 to inform the new ANSWER programme (supported by the Netherlands) to advance adolescent SRHR in West Nile and Acholi sub-regions. A mapping exercise was conducted in 2019 to identify potential implementing partners to work on community-based interventions, including GBV prevention and response. In addition, in 2020, a facility assessment was conducted in 130 public health facilities to determine health system gaps in SRH service delivery, in particular EmONC, family planning and PAC services. Provider competencies were assessed to be low for family planning counselling, infection prevention and commodities stock management. Access to manual vacuum aspiration procedure (to treat incomplete abortions) was absent in lower-level facilities due to lack trained staff, or lack of equipment for trained staff.

In particular, UNFPA programmes that include adolescents and youth must contend with the persistent, high teenage pregnancy rate (25 per cent) through holistic and integrated programming that address the links and pathways between GBV, SRHR and HIV. MHTF efforts contribute to addressing these pathways, as a significant proportion of pregnant women report experience of violence and are more likely to develop obstetric complications, including fistula. Child marriage and teenage pregnancy increase these and other health risks, such as sexually transmitted infections (STIs) and cervical cancer. The Sida-funded Joint Programme on GBV, the Danish-funded WAY

(women, adolescents and youth rights and empowerment), and the EU Spotlight programme are focused on SRHR-GBV integration, and where possible, include MHTF components, such as capacity building for midwives, strengthening EmONC services, improving QI and MPDSR processes and fistula camps.

Examples of integrated SRH-MNH programming conducted by UNFPA with MHTF funds include assistance to the UPMA to train and mentor private midwives to strengthen family planning counselling and clinical skills so as to include contraceptive services in 20 private maternities in under-served areas in Northern Uganda and Teso regions. Furthermore, EmONC training/mentorship for midwives includes integrated MNH and SRH components. Nevertheless, a 2017 UNFPA-supported assessment of EmONC services noted that there was “low availability” of family planning methods at facilities in 25 targeted districts. UNFPA is currently developing a “change package” to provide guidance on all the different supply and demand issues that must be considered and the changes that must occur at different levels of the health system to enable PFP service delivery. The change package is currently in draft and pulls guidance from different interventions to guide practical implementation.

Finally, UNFPA also supports integration through its routine coordination and management of MHTF activities. MHTF-supported advisors constitute the maternal health team in the Uganda country office and sit within the Department for Integration of SRHR (includes adolescent sexual and reproductive health and rights (ASRHR), HIV/GBV/SRHR integration team and family planning). This supports the integration of maternal health activities within non-MHTF projects and programmes, such as the earlier mentioned Sida-supported SGBV programme and the Netherlands-supported ANSWER adolescent health programme.

UNFPA approaches its work on the MHTF through the lens of integration and does what it can to link to other programmes that are resourced to address some of the broader, structural and socio-cultural challenges to achieve effective integration of services. These include capacity gaps and skills among providers for a full package of SRHR (including MNH) and GBV services, and by health system issues that affect the availability of human resources, supply chain management, and poor referral systems and unavailability of services at referral points. Although stakeholders often make the statement that “integration happens at the level of the service delivery point,” existing capacity is an issue, with the burden falling on midwives who are the focal point for clients for these services. There is the risk to the effectiveness of MHTF interventions, especially those requiring a strong midwifery cadre, when integration is pursued in the absence of a strengthened health system.

Strengthening access and equity

UNFPA has embraced a human rights approach and gender mainstreaming throughout its programming in Uganda. This has been achieved through the targeting investment of resources in hard-to-reach districts where there are few other projects or partners in place. Programme interventions, including those supported with MHTF resources, include an intentional focus on youth given that adolescent girls account for a significant proportion of maternal deaths in Uganda as a result of norms relating to early child marriage and pregnancy. This is especially true for the midwifery and fistula components of MHTF. However, the challenges are vast as compared to the amount of resources available to address them. As a strategy to leverage action beyond its limited resources, MHTF provided the framework to support the integration of safe motherhood components (i.e., EmONC, obstetric fistula) within its other larger programmes so as to strengthen equity and access.

For details of the evidence supporting findings in Section 3.6, see Annex 1: Assumptions 6.1, 6.2 and 6.3.

UNFPA programming is underpinned by “leaving no one behind” principle

UNFPA has embraced a human rights approach and gender mainstreaming in Uganda through programmes that target the needs of marginalized and vulnerable women, adolescents and youth. UNFPA and the MoH commissioned a study in 2018 to further define and differentiate the needs of sub-groups within the broad category of the hard-to-reach. Among the hardest to reach are those with multiple disabilities, victims of female genital mutilation (FGM), and women with fistula. In addition, UNFPA has targeted a group of 54 hard-to-reach districts, such as in the Karamoja region and Acholi sub-region. UNFPA selected these districts taking into account the context, region, whether the district hosts refugees or not, and the lack of other projects and interventions.

Equitable access to quality SRH-MNH services remains a challenge in Uganda

The challenges to the integrated services (Section 3.5) affect equitable access to quality maternity services, especially for marginalized and vulnerable women and girls. In particular, adolescent girls account for a significant proportion of maternal deaths in Uganda. This results from gender and social norms that encourage large families, early child marriage, teenage pregnancy and limited access to youth-friendly reproductive health services. Perspectives from key informants about challenges to equitable access indicate that UNFPA provides important assistance for filling some of the needs at the facility and community level, yet many more gaps remain unaddressed. The main challenges described by key informants include limited staff, poor infrastructure and supply shortages. In the rural, hard-to-reach areas there are not enough resources to conduct monthly outreach to all points (in accordance with service protocols). For those providers serving refugees, linguistic barriers and custom differences between host providers and refugee clients compounds difficulties in communication and care. Instances of women and girls being denied services because they came for ANC without their partners also speak to the persistent gender norms in the community that are also shared by service providers. Follow-up of GBV cases is also rendered difficult due to stigma and the lack of resources for home-based care and visits by service providers.

Intentional emphasis on gender equality and youth

Gender equality and women’s empowerment is an important thematic outcome area for UNFPA in the past and current Uganda country programme, on par with its other focus areas (SRHR and population and development), while youth continue to receive priority focus. UNFPA has a large portfolio of programmes for youth in Uganda to address life skills and empowerment, sexuality education, and adolescent SRHR. The government has also made strong policy commitments to address GBV and there are clear mandates for the government and other actors, including useful guidelines and protocols. However, there continue to be a gap between policy and implementation. Further, this area requires multisectoral cooperation and there are few mechanisms to hold the different ministries accountable for integrating gender equality, rights and gender transformative programming within existing GoU programmes.

UNFPA investments via MHTF complement programming with other funds to ensure equitable access

The MHTF provided the programming frame and supported activities (that were further complemented through other funding sources) to advance the capacities of the health system to carry out safe motherhood activities, i.e., emergency obstetric care, detect and report maternal and neonatal deaths, and prevent and repair obstetric fistula. UNFPA included maternal health components within efforts targeted to support vulnerable (refugee and host) populations in humanitarian settings (EmONC services, midwife deployment). For example, in 2018, UNFPA training of trainers (ToT) for MoH in the Minimal initial service package (MISP) identified a need for the inclusion of quality EmONC services. UNFPA also supported capacity building of health care workers, and especially midwives, through training and strengthening coordination, supervision and mentoring. In addition, UNFPA also recruited, deployed and supported salaries for midwives in

service delivery points for refugee settlements in selected humanitarian districts in order to ensure access to skilled birth attendance.

MHTF resources contributed to enhancing performance of midwifery services in underserved areas. The sponsorship of poor, marginalized girls in underserved target districts for bonded pre-service midwifery education increased access in underserved target districts (Section 3.1). While this strategy has been successful in the places where it has been implemented, its impact will be limited until it is scaled-up by the government. MHTF resources also supported a landscaping analysis to design evidence-based interventions for effective planning, resource mobilization and implementation of adolescent health in Uganda. UNFPA also introduced, in 2018, the GetIN mobile app, an innovation designed to increase access to maternal health services by pregnant adolescents through timely identification and systematic follow-up of the girls in their communities. In Bundibugyo district, UNFPA supported the training of midwives and village health teams (VHTs) to map more than 400 pregnant girls into the system, resulting in an increase in the number of girls seeking ANC and facility-based births. A formal evaluation is planned to determine opportunities to scale this technology up. Finally, the MHTF inputs related to youth have complemented the UNFPA “Live your Dream” campaign, which targeted adolescents through a multi-channel approach to engage communities to address factors that prevent girls from reaching their full potential.

Catalytic support

MHTF support contributed to two main types of catalytic programming. First, MHTF investments were used to support a “proof of concept” and leveraged the initial experience to engage donors to support its wider implementation through donor agreements in UNFPA target districts, i.e., the roll out of the midwifery GIS and MPDSR support to additional districts with Swedish and the Netherlands funding. The second type of catalysis focuses on upstream policy and advocacy activities to promote action by others. For example, UNFPA support to improve functionality of the fistula TWG has triggered important shifts in the national strategy to end obstetric fistula. Likewise, MHTF funding to support the compilation of the annual MPDSR report has led to the commitment of the MoH and others, such as USAID, to invest in capacity-building efforts in districts they support. Both types of catalytic support are facilitated by the technical role UNFPA plays with the MoH. However catalytic support only goes so far and the gaps that UNFPA intends to address require scaled-up and sustained resources beyond what MHTF can offer. UNFPA does not explicitly address the issue of sustainability as critical for optimizing the catalytic effects of MHTF investments.

For details of the evidence supporting findings in Section 3.7, see Annex 1: Assumptions 7.1, 7.2 and 7.3.

UNFPA plays important technical role for the MoH in maternal health and SRHR programming

UNFPA is recognized as a key technical partner for the MoH by the MoH itself and other development partners. UNFPA is now in its ninth country programme cycle (2021-2025) and has been a steady and trusted partner for the GoU and the MoH for several decades, enabling UNFPA to play a role in long-term strategic thinking and planning. This long-standing relationship is seen as an important factor for success, as is the placement by UNFPA of technical staff within the MoH at the national level to provide hands-on assistance. The presence of UNFPA staff in decentralized field offices also enables close coordination with DHOs in the implementation of activities within districts.

Leveraging political and financial commitment through MHTF actions

Catalytic actions are those that provoke or accelerate relevant change or progress that would not have occurred otherwise or would have occurred only very slowly (see rationale for evaluation question 7). There are several examples where investments by UNFPA resulted in others taking action and moving a particular approach or intervention forward. UNFPA used two main approaches to support catalytic programming.

The first approach has used MHTF funding to demonstrate the feasibility and potential impact of a programme intervention (i.e., as a “proof of concept”) and then leverage the initial experience to engage donors to support its wider implementation (through donor agreements) in UNFPA-supported districts. This approach, which also serves to mobilize resources, was used for the MHTF support to the development of the GIS system to map the licensing and registration of midwives. Sida is now funding an expansion of the GIS in 15 additional districts through the SGBV programme. (Sida also picked up funding MPDSR and fistula camps in this programme). Likewise, the Netherlands-supported ANSWER youth-focused SRHR programme includes resources to support district level MPDSR committees as well as mentorship by specialist teams from NRHs to follow-up issues identified through MPDSR reviews in selected districts.

The second approach focuses on upstream activities, whereby UNFPA catalyses and promotes engagement and action by partners through advocacy, policy dialogue and strategy development. This approach is well illustrated, mainly in the MHTF outcomes of fistula and MPDSR. UNFPA support for ensuring functionality of the fistula TWG has triggered structural shifts in the national strategy to end obstetric fistula. In particular, through its partnership with Terrewode, UNFPA has increased awareness of needs for a more comprehensive approach to care for women with fistula, including the need for social support for reintegration. Given the disruptions from COVID-19, the national fistula strategy is yet to be implemented. Thus, it has not yet resulted in committed action by others to expand fistula care to include reintegration. However, there is an increased awareness of its importance by government stakeholders at national and district levels.

The best example of the catalytic effect of the MHTF is to be found in the MPDSR sector. The MHTF support to the compilation of the annual MPDSR report has been instrumental in advocating and raising awareness about the key gaps and systemic issues to tackle with a view to reducing maternal mortality. The evidence generated in the annual report, magnified by UNFPA advocacy, has solidified the commitment of the most senior health officials to participate in the reviews and to support recommended actions. Taking note of this high-level commitment (catalysed by UNFPA), other actors (notably USAID and UNICEF) decided to support MPDSR capacity building in regions and districts (they support), hence reaching well beyond the UNFPA targeted districts. (Section 3.4)

Expectations for UNFPA are out of sync with the notion of catalytic funding

The capacity of MHTF to make its (meagre) resources catalytic depends on the ability of UNFPA to raise awareness on complex and structural challenges that require political commitment, system-wide planning and strategic scaling-up of limited resources. Yet, since UNFPA is perceived as the leading partner in maternal health by the MoH, there is a constant refrain by stakeholders (at all levels) for UNFPA to contribute the resources needed to support interventions to address the extensive gaps in human resources, equipment and supplies. Few implementing partners, especially at sub-national level, understood the catalytic nature of MHTF funding.

The UNFPA country office staff understand that, in order for the MHTF to be catalytic, there should be greater emphasis on the generation of evidence to influence discussions and resource mobilization by others. To this end, and in addition to the annual MPDSR report, UNFPA has supported a range of assessments with MHTF funds to provide evidence to inform strategies and interventions (i.e., quality of care in EmONC, fistula reintegration, NICU services at NRH-Kawempe). The UNFPA country office feels, however, that the greater emphasis on and priority they have been placing on evidence generation is not matched by the work, within the MHTF, at global level and this disjoint is detrimental to their capacity to further the catalytic role of the MHTF in Uganda.

Governance and management

UNFPA plays an important and significant coordination role in SRH-MNH in Uganda by virtue of its convening authority and significant engagement in various TWGs within the technical coordination platform of the MoH (the MCH Cluster). Coordination at national level is complemented by a

network of seven decentralized field offices to support implementation in targeted districts. Partners value UNFPA technical capacities, field presence and deep understanding of the Ugandan context. However, as UNFPA has increased its portfolio of bilateral programmes, its focus on implementation is perceived as diluting its leadership role with the MoH. Further, development partners find it difficult to see the linkages among the different country programme components and have called for stronger integration of the different pieces into one, strategic whole. Operational guidance that promotes integration within MHTF and across MHTF and other SRHR programme areas is lacking.

For details of the evidence supporting findings in Section 3.8, see Annex 1: Assumptions 8.1 and 8.2, and Assumption

Coordination to advance the MHTF objectives in Uganda

The convening power of UNFPA, coupled with its relationship with the MoH is well-suited to the management of MHTF inputs, especially through upstream policy and advocacy activities. Stakeholders appreciate UNFPA for its ability to gather multiple stakeholders ranging from government, civil society, the private, not-for-profit sector, development partners, academia and private institutions. This has helped UNFPA take leadership and coordinate the interventions of diverse partners in the four MHTF technical areas. As for the MoH, it considers UNFPA as one of the leading partners in MCH and appreciates its support across the continuum of care as well as its work in supporting policies and guidelines and their implementation. The country office is clearly committed to maintaining its influence in maternal health as an essential part of its strategic portfolio. To this end, it values the important role that MHTF plays for cultivating its leadership position.

At national level, UNFPA plays a visible and significant role in contributing to the functioning of various TWGs (under the leadership of the MoH MCH Cluster) to advance policy and guidelines development (and the process for their approval). The MCH Cluster is the technical forum for strategic issues for SRHR-MNH and includes all related TWGs (such as the fistula TWG) under its purview. UNFPA participation in the MCH Cluster and TWGs provides the organization with an important forum for advocacy with a view trigger interest and action from others within the MHTF partners community. As noted earlier (Section 3.5), UNFPA contributed to the quality of care tools and indicators, the family planning costed implementation plan (which includes PFPF as a priority), MPDSR tools, and fistula costed national strategy. However, until recently, there had not been a clear forum for coordination related to midwifery and EmONC until mid-2021, when the MoH started to include discussion of midwifery and EmONC in MPDSR meetings.

“Midwifery as a technical area – we don’t discuss that – I don’t even know what is under midwifery – I know we discuss at the celebration of the national day – so it is not clear what the work is under midwifery. Maybe that is discussed in other platforms, but not in the MCH cluster.” – A development partner

Development partners agree that TWGs are good places for sharing information and some have indicated a desire for UNFPA to exert leadership and proactively reach out to partners to foster more deliberate and intentional coordination in areas of mutual interest. One donor felt it was left up to them to call joint meetings to ensure that strategic coordination is happening between its partners, including UNFPA.

With regard to coordination with other United Nations funds and programmes, the coordination between UNICEF and UNFPA is noticeable in terms of avoiding duplication in regions where they are both active and supporting EmONC and MPDSR interventions. UNFPA also coordinates well with WHO, especially in MPDSR policy, given the latter’s role in technical guidelines development. Much of the coordination happens through the TWGs under the MCH Cluster.

However, UNFPA is not using the MHTF as a platform for strategic coordination with other United Nations partners for programming with the MoH or for joint resource mobilization. One interviewee felt that UNFPA was missing important opportunities to promote the complementarity between UNFPA, UNICEF and WHO in maternal health and to attract more donor resources.

“Maternal health should be one of the easiest areas to advance together, but we haven’t done that here at the country level.” – UNFPA Uganda staff

Balancing leadership and catalytic role with implementation

The leadership and coordination with the MoH and other partners through UNFPA technical assistance at national level is complemented by a network of seven decentralized UNFPA field offices to support implementation of UNFPA activities in target districts. The field offices help to foster visibility for UNFPA and enhance coordination and technical assistance. In particular, the MoH appreciates UNFPA engagement at both policy and service delivery levels, as it provides a foundation for having a good understanding of the field context and facilitates flexible responses to problems.

However, partners note that there are challenges in realizing the full potential of linkages between policy and implementation. UNFPA is considered a strong partner who can influence the MoH, but they tend to “go into implementation/operation mode” as if they were another civil society organization, instead of prioritizing their role as a key technical partner to the MoH. As UNFPA attracts additional donor funding for specific implementation of projects, there is concern that the focus will be on meeting donor requirements for the project(s) instead of maintaining strategic focus on what needs to happen at the national level.

While national level coordination is seen as good, district level coordination is hampered by the channelling of funds. Funds for district go through the MoH centrally, and then are directed to the local level. Other partners working in a district pointed to the lack of transparency on “what” the funds actually cover, which led to difficulties in bringing the DHO to the table for programme discussions.

Integrating within MHTF and across other technical areas

Country office staff spoke frequently during interviews about how the four technical focus areas of the MHTF are synergistic and contribute to the overall strategy to prevent maternal deaths. There are many examples, at policy and at the operational programmatic level, where UNFPA successfully advocated for integration (Section 3.5), such as for the development of SRHR, HIV and GBV integration policy and establishment of national coordinating platforms.

However, development partners find it difficult to see the interconnectedness among the different components of the country programme. Different areas of technical expertise are not yet being brought together, particularly at the field level. Another challenge is that UNFPA manages its activities and partners through an “output-based management process.” In other words, the individual pieces have been prioritized for implementation, rather than through a comprehensive or strategic approach that addresses all components synergistically.

UNFPA has been open to feedback from its donors and is working to bring together all its funding streams to advance access to an “integrated package of rights” in Uganda. At the organizational level, this has resulted in the restructuring of the country office to facilitate the integration of different programmes and foster collaboration across technical teams. The two MHTF-supported technical advisors sit on this team and participate in technical reviews of the other programmes (family planning, integrated SRHR, gender and women’s empowerment, etc.).

The country office also developed a checklist to support staff in identifying different entry points for ensuring the work they are doing is being considered for integration (a key strategy under the 9th country programme). Some staff spoke of the challenge to shift the mindset and working culture from vertical to integrated thinking in order to improve the effectiveness and efficiency of

programming. MHTF funding supports the integration of “pieces” of the maternal health agenda in other larger, bilateral programmes. Country office staff would welcome clearer guidance from the UNFPA headquarter team on the integration of maternal health into other SRHR activities, particularly for catalytic MHTF resources.

“As long as it (guidance on integration) is unclear at global level, it will be so at country level.”
– UNFPA Uganda staff

The need to integrate community engagement within the MHTF focus areas was also pointed out as challenging area by the country office and MoH. It is well understood that MPDSR programming links community structures and systems to health facilities as does reintegration care for fistula clients (although this is a new development). Yet, the MHTF is oriented to supply aspects of health system strengthening and does not address the cultural barriers that prevent beneficiaries from seeking appropriate and timely care.

The role of headquarters and regional office in relation to MHTF activities at country level

The MoH, MoES and other partners value the partnership with UNFPA, including its technical capacities, its field presence, and its deep understanding of the Ugandan context. They, as well as other partners did complain, however, about delays in fund disbursement and their effect on reducing and/or telescoping the period available for implementation of activities. Stakeholders view the technical expertise available through the MHTF advisors as a valuable contribution in the different focus areas. It is clear that the well-defined, clear model for MHTF activities has shaped the UNFPA portfolio for maternal health activities in Uganda. The country office receives technical assistance mainly from the East and Southern Africa regional office (EASRO), with much of it for integration through the “2gether4 SRHR” regional programme. On the other hand, there was little mention of technical support for MHTF headquarter team and the country office staff raised the lack of flexibility in the planning template and indicators for MHTF. They expressed the need to consider other areas (such as demand creation) that might be as much, or even more catalytic than what is envisioned in the current business plan.

COVID-19

The government response to the COVID-19 pandemic and the resulting restrictions in movement have indirectly impacted SRH-MNH due to diminished access and health-seeking behaviours because of fear of contracting the virus. UNFPA was quick to respond to the emerging COVID-19 pandemic, and along with other key development agencies, supported the MoH to develop guidelines to ensure continuation of essential services, provide personal protective equipment (PPE) and support access through the provision of fuel cards for ambulances to enable mothers to access services and critical staff to reach the health facility. UNFPA offered a flexible response through the reallocation of MHTF, and other resources earmarked in 2020. Although certain activities were disrupted or suspended because they required in-person gatherings, the UNFPA country office managed to maintain the momentum through a shift to virtual, online platforms for coordination and training (despite challenges for rural participants with poor internet connection). Activities on fistula were the most impacted due to the inability to conduct camps, which, in turn, has fuelled the already existing backlog of repair cases.

For details of the evidence supporting findings in Section 3.9, see Annex 1: Assumptions 9.1 and 9.2

The COVID-19 pandemic in Uganda

A recent study²⁴ found that Uganda, as with many nations in the Africa region, largely avoided the death toll from COVID-19 that other nations saw in 2020 thanks to its early, rapid and severe response. However, the response indirectly impacted SRH-MNH due to diminished access and fear of contracting the virus in facility settings. Antenatal attendance, immunizations and SRHR services were reduced and there was an increase in pregnancy complications and foetal and infant outcomes, likely due to care seeking behaviours.

“In the early days, during lockdown, there were gross limits to access, because of overall restrictions of movement, so there was low performance, very low uptake of family planning. Of all the MNCH indicators, family planning had the biggest drop, and uptake was very low, especially in April 2020. It recovered from June and above, when MoH came in to establish the weekly meetings for “continuation of essential services” and many partners came in to support the response and to ensure continuation of essential (including SRHR) services.” – An MoH official

At the end of 2020, UNFPA estimated that over 1.2 million pregnant women in Uganda faced increased challenges accessing lifesaving SRH services as a result of the pandemic. Because of school closures and lockdowns, the teenage pregnancy rates increased by 1.55 per cent in UNFPA supported districts. The Ugandan police reported a 10 per cent increase in GBV cases in 68 districts, and a 17 per cent increase nationally.

UNFPA acted quickly and flexibly to support essential SRH-MNH services

UNFPA was quick to respond to the COVID-19 pandemic and, with other partners, supported the MoH to produce the *National Guidelines for the Continuation of Essential Services* and the *RMNCAH COVID-19 National Guidelines*. UNFPA, along with UNICEF, USAID and others, provided the MoH with PPE to support essential service delivery by MNH workers. PPE included face masks, surgical masks, gumboots, gloves and sanitizers. In addition, UNFPA supported fuel cards for ambulances to facilitate transportation of mothers and adolescents to access services, for health workers residing far from facilities, and to transport blood when the supply became scarce during the lockdown. The MHTF resources were used to facilitate referrals of 5,000 mothers in 55 districts. In Gulu and Pader districts, over 2,600 mothers were supported with transportation for facility-based deliveries and 51 mothers received emergency care.

In addition, UNFPA supported a revision of the MoH workplan to conduct training and mentoring of service providers in COVID-19 infection prevention and control strategies as well as linkages to SRH and GBV. UNFPA supported the printing and dissemination of IEC materials about risk communication in local languages. Some training was adapted to online platforms to enable some capacity-building interventions to continue in spite of the lockdown. However, online platforms were not easily accessible for rural participants due to limited internet connection (availability and cost). While coordination activities were not substantially affected, the pandemic caused suspension and disruption of activities that required in-person gatherings. Only one fistula camp was held in 2020, adding to the backlog of fistula clients.

MoH officials at national and district level highly appreciated UNFPA for policy and material support for essential services. District level meetings with MCH partners were initially disrupted by COVID-19 but have since resumed.

²⁴ Burt JF, Ouma J, Lubyayi L, et al. Indirect effects of COVID-19 on maternal, neonatal, child, sexual and reproductive health services in Kampala, Uganda. *BMJ Global Health* 2021;6: e006102. doi:10.1136/bmjgh-2021-006102

Redirection of MHTF funds to respond to COVID-19

UNFPA reallocated available MHTF resources earmarked in 2020 to the COVID-19 response in a flexible and strategic manner. They redirected funding away from activities that could not be implemented due to the lockdown as well as from those activities that did not relate to the delivery of essential services. For example, funds were reallocated to COVID-19 from budget lines supporting attendance by country office staff and MoH partners to the International Society of Ob/Gyn fistula conference and global fistula TWG meeting, the ICM conference in Bali, and global MHTF meetings. UNFPA also reallocated funds for COVID-19 from activities under the EmONC component, i.e., to support mentorship and the rollout of quality of care standards in one district.

CONCLUSIONS

A small amount of funding has led to tangible results

UNFPA has delivered tangible results through its strategic use of limited MHTF resources to advance MNH in Uganda. It has significantly contributed to midwifery, MPDSR and fistula programming, but less so for EmONC.

UNFPA has utilized a small amount of funding, less than USD 1 million over a three-year period, to deliver important results in three of the four technical focus areas of MHTF. UNFPA leveraged its strong relationship and technical advisory role with the MoH to influence policies and commitment. This upstream work was coupled with capacity-building in service delivery, utilizing a combination of MHTF and other resources to advance implementation in targeted districts. The strategic combination of MHTF and other resources contributed to the perception by stakeholders of a significant contribution by UNFPA in the maternal health space, notably for:

- **Midwifery:** UNFPA has played a unique and significant role in increasing awareness about the critical importance of midwifery in achieving national health goals in MNH and SRH care. It has addressed many of the key components in midwifery programming as prescribed in global strategies in an attempt to systematically improve the overall environment for this cadre. Contributions include codifying regulations, strengthening education and workforce planning and building capacity of the midwives' association.
- **MPDSR:** MHTF was instrumental in establishing the MPDSR process, generating high-level political commitments and mobilizing resources from other organizations. Critical contributions included the costed implementation plan and annual data analysis, which serves as major catalyst for action. Increased political will has translated into action as a result of MPDSR reviews, such as the development of new guidance to improve the management of PPH and addressing blood bank shortages.
- **Fistula:** UNFPA policy and advocacy work at national level has increased awareness, enhanced partnerships and increased resource mobilization for UNFPA efforts and those by others.

UNFPA contributions to improved EmONC access were less defined and visible during the three-year period as this technical area was implemented through the entry points of midwifery and MPDSR components.

The MHTF has enhanced UNFPA leadership role in maternal health in Uganda

The MHTF provides a critical platform for UNFPA leadership in maternal health in Uganda; without it, the country programme would have little visibility for this important strategic outcome area for UNFPA.

MHTF provides an organizing framework for UNFPA to address the "one of the three zeros" or transformational results in the organization's strategic plan, i.e., zero preventable maternal deaths by 2030. Without the investments from MHTF, it is hard to see how UNFPA would have had the

opportunity to increase awareness of and commitment to fistula, midwifery and MPDSR in a significant way. Putting these issues on the map has been highly appreciated by the MoH, as the main partner of UNFPA and has given increased credibility to UNFPA in the large and expansive coordination platforms and working groups led by the MoH. The convening authority of UNFPA is also recognized and appreciated by development partners, particularly its ability to bring together actors from different disciplines and sectors to address SRHR matters.

The UNFPA reputation as a trusted partner was advantageous in positioning its assistance to the MoH in support of a flexible and rapid response to the COVID-19 pandemic both at national and sub-national level to ensure the continuation of essential services. UNFPA, in very close coordination with MoH and other development partners, enabled a strong response to ensure continued access to essential SRH and MNH services via coordination meetings, development of policy directives, mapping of resources to mitigate duplication and mobilization of resources through reallocation of MHTF and other resources. Programme momentum was preserved as much as possible through virtual platforms.

The well-defined focus of MHTF offers both advantages and limitations

The MHTF construct as outlined in the Phase III MHTF business plan strategically guides investments and activities at the country level and facilitates programming by the country office in the four technical areas. However, the construct does not adequately address cross-cutting issues such as quality of care nor does it promote clear linkages for addressing demand-side factors that impede access to MNH and SRH services.

The main advantage of the MHTF is its provision of guidance and evidence to support programming at country level, without the country office having to “reinvent the wheel.” The MHTF partnership at global level facilitates access, by country offices, to technical guidance from global partners, such as ICM for midwifery education and association strengthening and the Global Campaign to End Fistula, for guidance on reintegration. Using the tools available at the global level has contributed to important assessments conducted at country level to inform strategies and plans.

However, the MHTF focus on four pre-determined technical areas, is construed as a lack of flexibility by the country office and limits its ability to adapt to the local context and the unique position of UNFPA in Uganda. For example, midwifery could serve as a central pillar given the unique role UNFPA plays in advocating in this area. However, the perceived need to work in and allocate funds for four technical areas, constrains the strategic elevation of one area over the others.

The well-defined focus areas also result in limitations to integration across the four technical areas. Specifically, the need to report on the four outcome areas obfuscates important linkages, for example between the midwifery, EmONC and fistula components of the MHTF, especially in relation to quality of care. Quality improvement is acknowledged by UNFPA (and its partners) as a cross-cutting intervention for SRH-MNH services, yet there is no overall strategic or coherent map for how to promote, scale and report on QI efforts. Capacity building and mentorship activities, while seen throughout MHTF reports, are not linked to a larger, overarching outcome related to quality of care.

Further, the MHTF activities in Uganda focus mainly on addressing supply side barriers to pregnant women and girls receiving timely and quality care in emergencies. The decision by these women and their families to seek emergency care too late accounts for the majority of maternal deaths, yet there is no systematic attention to demand-related guidance through the MHTF. It is not evident whether this is a resource or capacity issue for UNFPA; nevertheless, for MHTF interventions to be more impactful, a greater focus on demand is needed whether it is implemented directly by UNFPA or through advocacy.

The MHTF interventions in Uganda are well-grounded in the broad vision to deliver an “integrated package of rights” and the principle to “leave no one behind”

UNFPA is clearly working to bring together all its funding streams, including the MHTF, to advance access to an “integrated package of rights” in Uganda, and with a focus on reaching vulnerable women and girls. Linkages within the SRH-MNH-GBV programmes are weakened by the difficulties inherent in managing a patchwork of donor-funded activities, and by the structural challenges that exist within the Uganda’s healthcare system.

UNFPA manages the MHTF investments to deliver an integrated package across the continuum of RMNCAH care. This is accomplished by including MHTF-related interventions in programmes funded through other resources. In addition, staff supported by MHTF resources operate as part of an integrated team for SRHR, which ensures that MHTF advisors contribute to the inclusion of MNH activities within ‘other-funded’ SRHR programmes.

The MHTF resources are targeted to vulnerable women and girls, mainly through the fistula programme as well as the young midwives’ scholarship programme. In Uganda, UNFPA has prioritized hard-to-reach regions and, when UNFPA service and capacity interventions are implemented through a combination of MHTF and other resources, they occur in targeted, underserved districts where few other partners operate, including in humanitarian contexts. MHTF efforts are linked to initiatives that underscore the vulnerability of young girls from early marriage and pregnancy; however, there is little evidence that these meet the needs of those with disabilities. However, the lack of an identifiable MHTF strategy for integration results in missed opportunities to strengthen linkages across the patchwork of different donor-funded activities or to mitigate the structural and socio-cultural challenges of the health system that affect effective implementation of an integrated package of rights.

The MHTF focus on catalytic investments does not sufficiently address scale-up and sustainable change

Small investments by the MHTF have leveraged important change in maternal health policy and programming but fall short of addressing what comes next in terms of mainstreaming and sustaining efforts.

The MHTF has contributed to two main types of catalytic programming. First, the MHTF leveraged its initial experiences in fistula and MPDSR to engage donors to support wider implementation through donor agreements in UNFPA target districts. The second type of catalysis focuses on upstream policy and advocacy activities to raise awareness of technical issues and bring other donors and partners on board to support actions related to the focus areas for the MHTF. This has worked especially well with MPDSR where other partners have introduced MPDSR in districts where they are implementing programmes.

Although UNFPA has integrated midwifery and fistula within their non-MHTF programmes, they have not significantly catalysed others to support these efforts in a big way. It has worked well for UNFPA to use the combined modes of engagement for policy and advocacy at national level with capacity building at sub-national level to make the case for expanding efforts. Therefore, MHTF has been catalytic for its own resource mobilization for UNFPA to extend interventions within their targeted districts, but less so at a broader level through other partners.

However, the structural challenges in maternal health require systemic change and the scaling-up of proven, evidence-based interventions. For example, MPDSR has been rolled out in areas where partner funding exists and yet district managers still do not have adequate or flexible funding to address actions recommended by the review process. Fistula care is also heavily donor dependent, and the reintegration component requires a much broader, multi-sectoral response that goes beyond

the limited efforts by NGOs in Uganda. Likewise, the MHTF efforts in midwifery have not extended beyond the areas covered by UNFPA. GIS and midwife scholarships, in particular, were only rolled out in UNFPA targeted districts and have not yet been transitioned to government.

Given the large and complex MNH needs in Uganda, the MHTF has not delineated specific strategies to foster the mainstreaming of interventions by the government, nor to address sustainability issues.

OTHER MATERIALS FROM THE EVALUATION

Available on the UNFPA Evaluation Office [website](#)

- Evaluation report
- Evaluation one-page brief (En, Fr)
- Executive summary (En, Fr)
- Evaluation presentation
- Annexes (Volume II)
- Country case studies (Benin, Sudan, Uganda, Zambia)
- Management response
- Evaluation Quality Assessment

Mid-term evaluation on the Maternal and Newborn Health Thematic Fund, Phase III, 2018-2021

Brief | Read the full report at [unfpa.org/evaluation](#)



Ending preventable maternal deaths is one of the three transformative results of UNFPA and includes an emphasis on integration of sexual and reproductive health and rights (SRHR) with maternal and newborn health (MNH) services. The Maternal and Newborn Health Thematic Fund (MNTF) delivers **technical and financial support** in 32 high burden countries to create **analytic and accelerated progress** in midwifery, emergency obstetric and neonatal care, maternal and perinatal death surveillance and response processes, and the prevention and treatment of fetal and other congenital conditions.

This evaluation assesses the extent to which the MNTF Phase 3 has contributed to **strengthening health systems, improving quality of care, and advancing equity, human rights and accountability to stakeholders** in partner countries, as well as its ability to **scale-up integration of SRHR and MNH services**.

DATA COLLECTION METHODS

- 32 countries
- 6 country case studies
- Field: Benin, Sudan, Uganda, Zambia, DRC, Bangladesh, Togo
- 180+ interviews
- 239 survey respondents
- 750+ documents reviewed

CONCLUSIONS

- With the MNTF, UNFPA is a partner of choice providing **valuable and valued support** to critical MNH priorities, with midwifery as the anchor of its interventions.
- The MNTF **delivers value for money** for individual countries and enables UNFPA to influence the MNH agenda globally.
- The MNTF is **not clearly positioned** within a holistic UNFPA MNH strategic framework.
- It **is not addressing critical gaps** (such as community engagement and quality of care measurement) that limit the relevance and sustainability of the MNTF investments.
- The MNTF **emerges to limited financial resources** effectively, but has not yet been **fully designed to deliver its 'catalytic effect'** systematically.
- The MNTF **addresses gender equality, human rights and equity**, especially among adolescents, but **does not**.
- The MNTF **successes contrast** with its low profile at UNFPA where its **significant and multifaceted contribution** to MNH remains insufficiently heeded.

RECOMMENDATIONS

- As the key UNFPA vehicle for SRHR/MNH integration and support, **continue and expand the MNTF** into a new phase
- Position the MNTF within a **comprehensive UNFPA maternal health strategy and action plan**
- Champion quality of care at the point of delivery**, including respectful care
- Be more systematic about integrating community engagement** across all MNTF activities
- Engage partners**, especially donors, more actively in the MNTF progress
- Improve the strategic coherence and responsiveness** of the MNTF
- Embed the focus on midwifery and the health workforce environment** across the MNTF
- Invest more in MNTF core added value:** SRHR/MNH integration and promoting catalytic results
- Refine results monitoring** to improve understanding and communication about the MNTF added value in different contexts
- Invest in innovative funding approaches** to attract an expanded donor base.

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Mid-term evaluation of the Maternal and Newborn Health Thematic Fund Phase III 2018-2022

Sudan

COUNTRY CASE STUDY

UNFPA Evaluation Office
2022

Mid-term evaluation of the Maternal and Newborn Health Thematic Fund Phase III 2018-2022

Zambia

COUNTRY CASE STUDY

UNFPA Evaluation Office
2022

Évaluation à mi-parcours de la phase III du Fonds thématique pour la santé maternelle et néonatale 2018-2022

Bénin

Bureau de l'Évaluation de l'UNFPA
2022

UNFPA Evaluation Office
2022

ANNEX 1: EVALUATION MATRIX

Area of Investigation 1: Midwifery	
Evaluation Question 1: To what extent has the MHTF contributed to ensuring the education, training, and deployment of an adequately skilled/competent, motivated and sustainable midwifery workforce?	
<p>Sub-questions:</p> <p>a) How has the MHTF contributed to strengthening the enabling policy and regulatory environment for midwives, including reinforced regulation of midwives (output 2) and increased use of gender-sensitive policies, strategies and plans to recruit, deploy and retain midwives (output 4), and policies to regulate the work environment for midwives, including supportive supervision, mentorship professional development, and assurance of a conductive and safe work environment (outcome 5)</p> <p>b) To what extent has the MHTF contributed to the capacities of a skilled and competent midwifery workforce, educated according to global standards and that meet national needs (output 1)</p> <p>c) To what extent has MHTF contributed to strengthening the capacities of midwifery associations to help raise the profile of midwifery, represent the professional needs of midwives, and provide professional support and continuing education? (output 3)</p>	
Evaluation Criteria	<i>Relevance, effectiveness, efficiency, sustainability</i>
Rationale	<p>Midwives play a central role as caregivers for women and their newborns throughout the continuum of care from pre-pregnancy to the post-partum period; and are positioned to provide comprehensive sexual and reproductive health information and services, including family planning, ANC, safe normal deliveries, basic EmONC, essential newborn care, prevention of STIs and transmission of HIV from mother to child, prevention of fistula and other morbidities, and prevention of female genital mutilation/cutting. To fulfil these roles, there is a need to strengthen midwifery education and training, enable and support midwife autonomy including ensuring midwives can work across their scope of practice, strengthen workforce policies and create a work environment that empowers midwives. These aims are central to achieving other outcomes of the MHTF, i.e., through expanded linkages with fistula prevention and elimination of female genital mutilation/cutting, in collecting, analysing and using data as part of MPDSR; and the deployment of midwives in EmONC facilities.</p>
Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional and national level, including in MHTF partner countries	
<p>Indicators:</p> <ul style="list-style-type: none"> • National policies, strategies and plans to govern midwifery practice and workforce capacity development, including supporting midwife autonomy, gender-sensitive policies, strategies and plans to recruit, deploy and retain midwives, midwifery included in Human Resource policies • Strengthened regulatory bodies that govern midwifery practice, certification, accreditation, monitoring and accountability and that regulate quality of care, client safety and satisfaction • Strengthened policies, guidelines and standards related to supportive supervision, mentorship, professional development, and a safe and conducive work environment • Views and experiences of partners and health authorities at global and national level regarding effectiveness of UNFPA leadership to advocate for evidence-based policies, strategies, plans and regulations 	

Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional and national level, including in MHTF partner countries	
<ul style="list-style-type: none"> Alignment of UNFPA policy inputs with MHTF core principles (equity, quality of care, accountability plus human rights and gender equality). 	
Observations	Sources of Evidence
<p>Strategic imperatives for reducing maternal deaths as identified by UNFPA (2017)</p> <ul style="list-style-type: none"> Revise staffing norms to align with increased in population Improve the working environment for midwives to ensure retention by providing adequate space, equipment, accommodations, etc. Address stock-outs/essential lifesaving medications, supplies and equipment Strengthen the referral system (both community and inter-facility) by providing ambulances and ICT equipment Prioritize support to rural areas and underserved districts; support local district government with recruitment Provide training bursaries for midwifery students with bonding to work in underserved districts Strengthen midwifery regulation and professional associations 	UNFPA Uganda, Population Matters Issue Brief 2, 2017
<p>UNFPA-MoH collaboration in midwifery</p> <ul style="list-style-type: none"> UNFPA has provided critical support to midwifery in Uganda, i.e., improving awareness (through midwifery days and associated events), improving policies for midwives (i.e. the scope of practice), and training and mentorship in infectious prevention control (IPC) during the COVID-19 pandemic. For the latter activity, UNFPA provided support to the MoH at national level, and then the MoH implements mentorship at the regional and district level. This activity was related to COVID-19 – IPC for midwives and conducted in the UNFPA-supported districts, i.e., Gulu, Arua, Naibi, Zumbu, Yumbe, Napak, Nakipiripirit, Moroto, and Kanungu. UNFPA has also provided funds for a consultant to support the MoH in the process to develop the national midwives’ policy (scope of practice for midwives), currently under development). 	Interview, MoH national staff, Kampala, Uganda, May 2021
<p>Midwife Scope of Practice policy</p> <ul style="list-style-type: none"> UNFPA supports the NMNC (under the MoH) to revise the midwives’ and nurses’ scope of practice. (The UNMC regulates the Nursing and Midwifery professionals in the country.) The revised version will enable midwives to perform assisted deliveries (vacuum extraction, etc.) to increase availability and quality of BEmONC services. The revision started in 2018 or 2019; it is not yet completed, but it is in the final stages and was sent to the Solicitor General to approve the legal aspects of the document. Feedback was given and now the next stage is to have stakeholders agree on the new aspects and scope of practice. 	Interview, MoH national staff, Kampala, Uganda, May 2021
<ul style="list-style-type: none"> The main area of UNFPA support in the policy and regulatory arena is the support for the Scope of Practice policy. MHTF kick-started the process and enabled UNFPA to develop the scope of practice as well as support the processes which are quite long and complicated. FCDO-UK support under the RISE (family planning) programme complemented MHTF funding. With cuts of UK funding, the Council is using its funding to ensure that the Scope of Practice policy process is completed. “The MoH helped mobilize additional support from Global. We have not yet entirely filled the funding gap for UNFPA.” 	Interview, UNFPA staff. Kampala, Uganda, May 2021
<p>Policy environment for midwifery recruitment and registration</p> <ul style="list-style-type: none"> “The midwifery programme in Uganda entails training midwives under the MoES and these midwives being examined by the Uganda Nurses and Midwives Examination Board (UNMEB). After graduation, the midwives are required to register and 	UNFPA Uganda, Population matters Issue Brief 13, 2020, p.1

Assumption 1.1: MHTF inputs regarding norms, standards, policies, and guidelines relating to midwifery address key gaps in existing policy and regulatory framework and environment for midwives at global, regional and national level, including in MHTF partner countries	
acquire practicing licenses from the Uganda UNMC before they are recruited in service. Recruitment of midwives in service is done by Health Service Commission at central level and District Service Commissions at district level. The commissions are mandated to appoint, confirm, promote and review the terms and conditions of service in line with the policies, systems and structures of the Ministry of Public Services. Midwives in service and those still at school are also encouraged to network and associate to improve the midwifery services in the country.”	
<p>Strengthening planning through scale up of GIS</p> <ul style="list-style-type: none"> UNFPA continues to support UNMC Council through the MoH to scale up the GIS, a system that tracks the presence of midwives and informs the MoH and MoES on the midwifery workforce requirements at each level. The system also tracks deployment of midwives to informs the HR needs/gaps for midwives. With support from the MHTF, UNMC sensitized leaders in seven districts of Moroto, Kotido, Napak, Nabilatuk, Kiryandongo, Yumbe, Kampala to understand and utilize the system. In the same districts a total of 563 Midwives were trained on how to use the system. Ten districts have been covered with support from the MHTF and an additional 10 districts have been covered with support from Sida, making a cumulative total of 20 districts where GIS has been introduced in Uganda. Cumulatively, a total of 1775 midwives countrywide have been enrolled onto the GIS. 	UNFPA Uganda, 2019 Annual MHTF Report, 2019, p.4
<p>The rollout of the GIS has resulted in the following:</p> <ul style="list-style-type: none"> From 2014 to 2019, compliance increased from 35 per cent to 74 per cent for renewal of practicing licenses, and from 54 per cent to 70 per cent for registration. GIS enabled a 60 per cent increase in revenue to the UNMC through timely payments of renewal and license fees by members. Ability of UNMC to perform due diligence and protection from practice by unqualified midwives. 	UNFPA Uganda, Population matters Issue Brief 13, 2020
<ul style="list-style-type: none"> UNMC sensitized stakeholders at national and district level on GIS. A total of 120 midwives and nurses from the 3-pilot district of Gulu, Lamwo and Kitgum were introduced to and oriented on System. 	UNFPA Uganda, UNFPA-MoH Annual Workplan Progress Report, 2018
<ul style="list-style-type: none"> To effect proper regulation of practice, UNFPA has initiated the processes with UNMC to establish a GIS that is being piloted in 3 districts. A total of 216 midwives have been initiated on the system. The aim is to effectively track the presence of midwives in the required places and also inform MoH and MoES on the midwifery workforce requirements. Thirteen Regional Licensing centres have been supported to enhance registration of midwives and renewal of licenses across the country this has improved midwives’ registration. A Midwifery GIS has been created and a dashboard for the whole country indicating number of midwives, personal details, facility and district locations. The system also shows the validity of the practicing licenses for the midwives and nurses. UNFPA supported UNMC to sensitize stakeholders at national and district level on GIS. A total of 120 midwives and nurses in three pilot districts (Gulu, Lamwo and Kitgum) were trained on how to input personal information into the GIS. 	UNFPA Uganda. 2018 MHTF Annual Report. 2018
<ul style="list-style-type: none"> “UNMC was supported to train midwives on GIS and sensitize district leaders to scale up the Midwifery GIS and register more midwives into the system in 20 more districts to make a cumulative of 40 districts. 	UNFPA Uganda. Final Annual Report for MHTF. 2020.

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<ul style="list-style-type: none"> Ten out of the 20 UNFPA supported districts are supported by MHTF to use GIS, with an additional 10 districts supported by Sida. A total of 3,049 midwives and 6,299 nurses were enrolled into GIS in 2020, for a cumulative total of 5,055 midwives and 10,602 nurses in the system. GIS coverage is 19 per cent of districts due to limited resources to facilitator rollout “with slow progress towards full implementation and integration of GIS into routine government processes for midwives by the Nursing Council.” (p. 20) In addition, there is limited server space and there is need for a dedicated server and full hosting of the system to MoH servers with reliable connectivity and integration/linkage to the MoH integrated Human Resource Information System. An implementation plan is required to support government and the Council to support full rollout of the GIS. 	
<ul style="list-style-type: none"> Uganda Nurse and Midwives Council (UNMC) registered 20,475 midwives; in Karamoja there was a 75.3 per cent increase in the number of positions filled in public health (an equivalent of 1 midwife for every 2,000 population). “To date, UNFPA has supported 590 girls from hard-to-reach areas like Karamoja to train as midwives under a bonding scheme, who upon graduating are recruited in their respective districts to reduce the staffing gap.” (p.2) “In 2017, UNFPA through MoH, with support from SIDA and the MHTF, supported UNMC to develop an efficient GIS that would capture, analyse and provide timely data on all midwives and nurses in Uganda. The GIS captures data on cadres of midwives and nurses available in the country; the licensure and registration status of midwives and nurses with UNMC; deployment and distribution of midwives and nurses, data on retirement; and production and absorption capacity by the public and private sectors.” (p.2) After piloting in the 3 Northern Uganda districts of Gulu, Lawmo and Kitgum, UNFPA has supported the rollout and utilization of the GIS in 28 districts of Uganda to help participating districts project human resource requirements for nurses and midwives. For example, in Gulu the Senior Principal Nursing Officer uses the GIS dashboard for reporting on the status of nurses and midwives to present to the District Health Service Commission to facilitate monitoring of staffing gaps, and planning for recruitment and deployment in the district. “Currently the training of midwives and nurses in Uganda is not based on need. To enhance need-based training, support is needed to link GIS with key line sectors such as MoES to improve planning for training midwives and nurses.” (p.4) Scale up and linkage to the MoES, the Ministry of Public Service and other bodies that are responsible for managing midwifery programmes (such as the Health Service Commission and the UNMEB) would facilitate evidence-based planning and effective implementation of programmes. 	<p>UNFPA Uganda. Population Matters Issue Brief 13. 2020</p>
<ul style="list-style-type: none"> The GIS project was started in 2018-2019 fiscal year. Prior to that, compliance with license renewals was 60 per cent; now, it is 73 per cent. The MoH TWG approved the GIS as the “de-facto system” for reporting nationally. Prior to GIS, it took about three years for license renewal as compared to annually in other countries. “It was a big black box – we did not know how many were practicing, how many retired or died.” In places where the GIS is not yet rolled out, nurses and midwives still have to come for manual registration. “UNFPA has a passion for midwives in the hard-to-reach areas and led us to have this GIS solution....which has improved registration, licensing, and meeting districts’ needs.” The GIS is a mapping system which helps register and license midwives and nurses. The GIS “communicates” or interfaces with the” integrated human resources for health” (iHRH) system (the national iHRH database) created with support from 	<p>Interview, NGO partner. Kampala, Uganda, May 2021</p>

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<p>IntraHealth and USAID). The MoH TWG is responsible for approving protocols for reporting. Thirteen regional registration centres were established in the regional referral hospitals. “We compare what we have in our GIS system and ask the DHO to give us data. We work with the Senior Principal Nursing Officer in the RRH, and they work actively with each Assistant DHO (for maternal health) to track and register the nurses and midwives in their districts.”</p> <ul style="list-style-type: none"> • The National Health Services Commission and the District Health Services Commission are responsible for recruitment. When districts hire, the national level does not get the information in real time. The aim of the GIS is to access and view data across districts using the online platform. UNFPA provided funding through the MoH to pilot the GIS in three districts and then added 24 more districts, with more to add this year. It supported validation exercises whereby the district was supported to ask all practicing midwives and nurses to present their degree certificates for validation and entering into the GIS. • An example of the GIS impact on quality is in the Kitodo district where the number of illegal practitioners was high. “The implementation of GIS resulted in the reduction of illegal practices and now it is one of the best performing districts.” 	
<ul style="list-style-type: none"> • When UNFPA first started supporting the Council, they only had one centre – every midwife and nurse had to come to Kampala for registration and licencing etc. UNFPA has supported the council to support the decentralisation to Regional Satellite Districts – in 13 RRH – so they can now re-licence. UNFPA supported them with computers, printers, so many other accessories that they use at their offices. In 2018, the GIS was developed to help track where nurses and midwives are, their status, whether they have a valid practicing licence – retired – helped the Council to better track/monitor. • GIS has been scaled up to 40 districts, 25 were funded by MHTF, the other 15 were Sida funds (joint GBV programme with UN Women). “We started with MHTF and when we saw results, we shared with ... when we were developed the Sida proposal – we shared the experience of the MHTF GIS, and they got interested and funded it.” 	<p>Interview, UNFPA Uganda national staff, Kampala, May 2021</p>

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education
<p>Indicators:</p> <ul style="list-style-type: none"> • Number of midwifery schools (public and private) supported by the MHTF that are accredited by the government based on global standards set by WHO and ICM • MHTF support for midwifery education programmes aligns with national needs. • Examples of MHTF support to strengthen capacity²⁵ of midwifery schools to provide quality pre-service training, including necessary teaching materials, commodities and equipment and incentives to motivate teachers and students • Examples of MHTF support for standardized, competency-based education programmes that bridge competency development trainings (i.e., in-service training, continuing education) for midwives and tutors • National midwife education programmes are aligned with global standards for competency-based training and accreditation

²⁵ The COM-B model of behaviour change (Mayne 2016) will be used to assess provider capacity based on three necessary conditions: 1) capability (necessary knowledge, skills, and attitudes to deliver quality care), 2) opportunity (having the necessary infrastructure, equipment, supplies and tools to deliver quality care), and 3) motivation (internal cognitive and emotional processes related to willingness and perceived personal benefit of providing good quality of services).

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education	
<ul style="list-style-type: none"> Views and experiences of partners, health authorities, and midwifery educators regarding the relevance, technical quality, and effectiveness of UNFPA support for midwifery education programmes. National programme plans include efforts to institutionalize²⁶ (sustain) standardized, competency-based education of midwives Alignment of UNFPA policy inputs with MHTF core principles (equity, quality of care, accountability plus human rights and gender equality) Number of innovations developed to enhance midwifery education and continuous training. 	
Observations	Sources of Evidence
<p>Responding to national needs</p> <ul style="list-style-type: none"> The main contribution of UNFPA is leadership on midwives and towards ensuring that midwives are increased in numbers. Their efforts to train and deploy midwives has improved competencies and to provide better maternal, newborn and child health (MNCH) services. They are training anaesthetists under the ANSWER programme, as this is one of the key gaps. Women who need C-sections must be referred to higher level facilities because there is no anaesthetist. 	Interview, Bilateral donor. Kampala. May 2021.
<p>UNFPA support for quality midwifery education</p> <ul style="list-style-type: none"> UNFPA has supported the improvement of quality of midwifery education via “training of 60 midwifery tutors, equipping midwifery skills labs and libraries in 20 midwifery training institutions, updating the midwifery curriculum to conform with International CICM and WHO guidelines, introducing the Structured Collaborative Clinical Training, conducting career promotion in secondary schools to inspire girls join midwifery as a career of choice; supporting the UNMC to decentralise its regulatory functions to 13 regional centres in order to improve on the registration and license renewal processes, supporting midwives to establish an association to improve on professional development, building capacities of the health workforce to provide quality sexual and reproductive health and rights (SRHR) services, equipping health facilities and strengthening the policy and legal environment under which midwives and other health workers operate in Uganda.” 	UNFPA Uganda. Population matters Issue Brief 13. 2020, p.2
<ul style="list-style-type: none"> With support from MHTF, “the Ministry of Education through the Teachers Instructor and Education Training Department conducted a joint monitoring and support supervision in 15 Health Training Institutions. The institutions were assessed and ascertained on the use of equipment in the skills labs, use of the libraries by the students and provision of mentoring and coaching to students in the skills labs and practicum sites on facilities for skills acquisition especially skills labs and the practicum sites and finally provided technical guidance and recommended further improvement.” 	UNFPA Uganda, UNFPA-MoES Annual Workplan Progress Report, 2018, p.14
<ul style="list-style-type: none"> With support from MHTF, “the BTVET Department of the MoES in charge of the Health Training Institutions conducted a three-day training, on using the Structured and Collaborative Clinical Teaching Training Model, a total of 25 Health Clinical Preceptors from various training hospitals were orientated in the model. The training concluded with the recommendations, and among which is the need to train more clinical Preceptors. Already UNFPA committed more funds to train additional 30 clinical Preceptors planned for Q4.” 	UNFPA Uganda, UNFPA-MoES Annual Workplan Progress Report, 2019, p.30

²⁶ Institutionalization means that the Ministry of Education and/or Health has adopted UNFPA-supported curriculum changes as their own standard for midwifery education.

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education	
<ul style="list-style-type: none"> • “The Ministry of Education was supported to train 20 clinical preceptors on Structured and Collaborative Clinical Training Programme (SCTP) for 20 EmONC Training sites to make a cumulative total of 60 with trained preceptors in this methodology for both 2019 and 2020. In addition, the Ministry through the Business, Technical, Vocational Education and Training (BTJET) conducted a workshop and developed training manuals for midwifery diploma and midwifery extension.” (p.3) • The goal for 2020 was to train 30 clinical preceptors; however, it was not possible due to COVID-19 restrictions. 	UNFPA Uganda, Final Annual Report for MHTF, 2020
<ul style="list-style-type: none"> • “UNFPA supported training institutions linked to 21 EmONC sites to train 60 Clinical preceptors in the application of the Structured and Collaborative Clinical Training Programme. The training is aimed at strengthening Midwifery Education thus contributing to production of better skilled midwives. In an effort to encourage and motivate the midwifery workforce, the Swedish Embassy in collaboration with UNFPA and MoH continues to recognize and award best performing midwives in the country. Midwives have continued to increase visibility through midwife led media activities where they exhibited midwifery services in communities to increase on demand generation for SRHR/GBV services and visiting schools to inspire young persons to join midwifery profession.” 	UNFPA Uganda, 2019 Annual MHTF Report, 2019, p.4
<ul style="list-style-type: none"> • Well-coordinated facilitative supervisions by MoES and key stakeholders including officers from MoH were done in 20 training institutions. Critical gaps and opportunities were observed, and recommendations and action plans were developed and to be followed up by the different stakeholders in this year. • A total of 30 preceptors from 10 hospitals attached to training institutions were equipped with skills to mentor and coach student midwives using the Structured and Collaborative Clinical Training Programme • Capacity to deliver the midwifery competence-based curriculum was built for 35 Midwifery tutors from the 20 supported training institutions • A total of 20 Midwifery institutions received skills lab equipment from Sida through UNFPA. This coupled with support supervision of the institutions and application of the Structured and Collaborative Clinical Training Programme in the practicum sites will strengthen Midwifery Education contributing to production of better skilled midwives. The Swedish Embassy in collaboration with UNFPA and MoH recognized and awarded 12 best performing midwives in the country. 	UNFPA Uganda, 2018 Annual MHTF Report, 2018
<ul style="list-style-type: none"> • UNFPA has contributed to the quality of midwifery education by supporting the revision of the midwife curricula, shifting from a subject-based to a competency-based curriculum. This has contributed to improving the quality teaching and facilitated “easy testing and assessment of learning”, although it is too early to say whether it has improved the competencies of the students (implementation only started in 2019 and was paused due to COVID-19-related closure of schools). “The curriculum guides very well – it is easier than before when the teachers were defining the assessment areas and it was not clear what they should or how to assess. The new curriculum shows clearly what a Year 1 student is supposed to know and able to do. It is also stated exactly what equipment, learning materials and human resources are needed for teaching this competency.” • UNFPA has also supported scholarships for teachers in midwifery schools – bringing them back to the college to become “tutors” (i.e. teachers), and once the education is completed, they go back to their teaching institution. “That has been a huge contribution of UNFPA – those sponsorships.” 	Interview, MoES, Kampala, May 2021.

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education	
<ul style="list-style-type: none"> Support was given to implement the “Structured Collaborative Clinical Teacher Training Programme,” a six-day training module to train preceptors – i.e. mentors based in the clinical areas in the hospitals responsible for supervising and teaching the midwifery students/interns. “In the past, some of them were not prepared to teach – but this model teaches those preceptors how to teach the students, to become good midwives.” The interviewee considered this one of the most significant contributions of UNFPA to midwifery in Uganda. 	
<p>Bridging the gap through recruitment, bonding and deployment of midwives:</p> <ul style="list-style-type: none"> UNFPA helped to bridge the gap in midwifery. In 2015/2016, there were few midwives in facilities. UNFPA helped to identify and recruit nurses, provide scholarships and send them to midwifery schools for further training. “We see those midwives when we go to the field.” In addition, the support for GIS within the public system is providing information about the deployment of midwives and nurses, and “responds to all our questions.” 	Interview, NGO partner, Kampala, May 2021
<ul style="list-style-type: none"> Overall, UNFPA has contributed to midwifery in Uganda and its efforts have yielded positive results. There have been some challenges in the hiring/deployment of the UNFPA-sponsored midwives in some of the districts. The bonding programme was supposed to improve staffing of midwives in Uganda in different districts by encouraging girls with low education at community level to become midwives. “We see that in Karamoja it really developed, and many of them were picked up and hired by the District Service Commission. But in some districts (other regions), it did not work – and this was because there were limitations on government, on how many midwives they can hire from the UNFPA programme, into those facilities. My personal opinion, this is a sustainability issue, how to make sure we collaborate with government to make that transition – from UNFPA to become hired by government. Maybe it worked in Karamoja because there was such a huge gap? I am not sure.” Regarding the recruitment and retention of bonded midwives, delays have occurred due to the limited wage bill ceiling allocated to the districts. However, the MoH has conducted annual emergency recruitment drives for health workers, which has helped to absorb the bonded midwives. The lack of government funding to take the midwives on and pay salaries remains an issue. 	Interview, Bilateral donor, Kampala, May 2021
<ul style="list-style-type: none"> UNFPA supports training for midwives in schools, mentoring for midwives, and award for the best performing midwives, in partnership with Sweden Embassy (Sida). There are currently no other partner/donor supporting midwifery education and practice than UNFPA/Sida. AMREF used to provide some support in the past, but no longer. The most significant gap is training of a sufficient number of skilled midwives, and if additional funding becomes available, it should be used for training more midwives (e.g. through sponsorships and support to midwifery schools) and deploying them in underserved areas where access is limited 	Interview, MoH national staff, Kampala, May 2021
<ul style="list-style-type: none"> UNFPA support for capacity development/midwifery education and training: MCH used to be a huge challenge in the district; this used to be a very large district before the division into several smaller districts. It lacked skilled midwives that used to be the biggest gap. UNFPA has provided capacity building for newly trained health staff/midwives. UNFPA sponsored the education of 17 midwives for the district, those midwives that were trained were selected by Gulu District Local Government and were sent to different midwifery school and hospitals across the country (even in Kampala) – 	Interview, MoH staff, Gulu District, Uganda, May 2021

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education	
<p>and then they came back to work in Gulu (after end of education). That is how UNFPA helped “lift” the human resources and helped to have skilled deliveries in health facilities, even Health Centre (HC) II – UNFPA supported training, when they came back, local government funded their salaries. UNFPA funded 3-year a training of midwives.</p> <ul style="list-style-type: none"> • The UNFPA-supported 17 midwives are now deployed in government structures or for private, not-for-profit providers (PNFP). They are all working, both government and private facilities. They finished in 2018/2019. Even some are now planning to go back for diploma – they were only “certificates”. 	
<ul style="list-style-type: none"> • UNFPA has provided support for training and sponsoring midwifery students since 2007. The Midwifery School in Agagao has received support since 2011 (teaching equipment; still in use today). Since 2015, UNFPA has supported girls from poor/disadvantaged districts to attend midwifery education (certificate). The districts lead the selection of students, who receive tuition and support and are then bonded for two years to return to the district. • The school received textbooks for the library for use by tutors and students, which facilitated teaching. UNFPA also supplies equipment for the skills labs, i.e., models, which improved the performance of students through demonstration and practice. In addition, a school bus was provided to support community outreach to hard-to-reach areas. The bus is used to take students to the community for two weeks for practicums as well as for integrated outreaches and national seminars at specialized hospitals. • UNFPA has also helped with mentorship, e.g., supported staff from the school to go to AMREF in Kenya for training of trainers in mentorship. (Note: this was in 2014.) • UNFPA is different than other donors/partners as they focus on sponsoring and deploying trained midwives to the hardest-to-reach areas, which helps save the lives of mothers and babies in those areas, as the women would otherwise not have access to a skilled midwife (without UNFPA support). “With the students sponsored by UNFPA, they send them to places where there is really a need for them to be, in areas that are really hard to reach, they ask them to go back there to work. These students are really working hard, with their heart, being appreciated by the communities. UNFPA put as a condition that they must go and work in very hard to reach areas – and that is of great benefit to that community. Not necessarily back to their own district, but in areas of greatest need. UNFPA takes the service far to those who need it the most.” 	<p>Interview, Government official, Agagao District, May 2021</p>
<ul style="list-style-type: none"> • UNFPA has provided scholarships for poor young girls to become midwives in the Karamoja sub-region, which they said has helped increase access to skilled midwives among disadvantaged and poor women. • School books and other materials are provided for those students and the midwifery schools. • The interviewees noted that districts usually have the funding to hire those midwives; the issue is rather attracting and retaining skilled midwives to come and work in remote areas, like Karamoja. The scholarship programme, using midwife students coming from those areas, has been successful in filling vacant midwifery positions in those areas, and retaining the midwives even after the bonding period ends. • “The biggest contribution is the training of preceptors (80 trained with UNFPA support) as they are mentors in health facilities and transfer skills to students. Support is funding, but not technical assistance. I went to Karamoja, deep down there, and saw students (sponsored by UNFPA) doing midwifery at a maternity hospital. I think it is very important, because these students are from there, and they will go back to serve there. It has been so hard to get people to go there and work. 	<p>Interview, MoES, Kampala, May 2021</p>

Assumption 1.2: MHTF support to strengthening midwifery education programmes are technically sound and appropriate, responding to national needs, and aligned to national and global standards for midwifery education	
So, if we target more of these hard-to-reach places and train people to go back to those places, it is really good. Government has the funding to hire them; the issue is recruitment.”	
<ul style="list-style-type: none"> UNFPA started the review of the midwifery curriculum with MHTF fund – and Sida has now funded the development of the training manual to deliver that curriculum. The training of the preceptors was also started with MHTF fund support, and it has also been taken up by Sida, and Austria. “Mainly, the activities that were started with MHTF support has been incorporated into the SIDA proposal, including the training and the bonding of midwives. The Sida-funded SGBV joint programme with UN Women started 2018/2019.” 	Interview, UNFPA Uganda national staff, Kampala, May 2021
Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support	
Indicators:	
<ul style="list-style-type: none"> Examples of UNFPA-supported costed strategic action plans for midwifery associations Examples of UNFPA-supported communication, advocacy and resource mobilization activities geared to strengthen capacity of midwifery associations Examples of capacity building actions by midwifery associations to provide continuous professional education, to build capacity of young midwifery leaders and to provide improved access to quality SRHR information by adolescents through social and traditional media Views and experiences of global and national leaders and members of midwifery associations regarding relevance, effectiveness and efficiency of UNFPA efforts Plans to sustain capacity building efforts within midwifery associations are in place and being implemented. 	
Observations	Sources of Evidence
Strengthening capacity of the UPMA	UNFPA Uganda, 2018 Annual MHTF Report, 2018
<ul style="list-style-type: none"> UPMA with MoH followed up and mentored 20 private midwives and their co-workers at maternity homes for those who received midwifery kits from UNFPA in northern Uganda and Teso regions. Midwives were mentored on EmONC and their role in the community. Findings from the mentorship included: <ul style="list-style-type: none"> 90 per cent of maternity homes/ clinics need remodelling to ensure standards improve privacy and infection prevention. Only three midwives had updates on long-acting contraception and only one had the skill to insert postpartum intra uterine device (IUD). In most health facilities, midwives needed skills for handling emergencies like PPH, neonatal resuscitation and Eclampsia. A 3-day training on long-acting contraception was conducted from Soroti district in December 2018 for 20 private midwives from UPMA. The training included theory and practical sessions at the regional referral hospital. 	
Strengthening capacity of the NMAU:	UNFPA Uganda, Final Annual Report for MHTF, 2020, p.3
<ul style="list-style-type: none"> “In 2020, the NMAU developed a costed strategic plan 2020/21-2024/25. This is the first strategic plan of the association which outlines the strategic vision and goals that have been identified to help the Association of Midwives realize its full potential and fulfil its mission to serve the Ugandan citizenry as well as the wider community as global citizens. An additional 	

Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support	
72 midwives were enrolled into the association during the International Day of the Midwife (IDM) celebrations at various health facilities. This makes a cumulative total of 326 members of NMAU.”	
<ul style="list-style-type: none"> • UNFPA provided support to hire a consultant to lead the development of the NMAU strategic plan. An inception report was presented to a multi-sectoral Advisory Committee at the MoH, and comments were incorporated into the draft strategic plan. UNFPA also supported capacity building to register nurses and midwives into the GIS in 9 additional districts. 	UNFPA Uganda, GoU/UNFPA Country Program Support to MoH 2019 Annual Workplan, 2019
<ul style="list-style-type: none"> • The Final Strategic Plan for the National Midwives Association of Uganda was available for printing and dissemination in the final two quarters of 2020. 	UNFPA Uganda, MHTF Mid-Year Report, 2020
<ul style="list-style-type: none"> • MHTF supported the establishment and registration of a midwives association that covers midwives working in the public, private and not-for-profit sectors. Prior to this, there was only an association working with private midwives. MHTF supported the development of its strategic plan, which will be printed and disseminated in 2021. • It is a young association and membership needs to be boosted. “They need to do a lot of recruitment and one of the things that MHTF supports is the IDM to ensure that more midwives are recruited during these events. This was a challenge in 2020 and the number of midwives who could join was very limited.” • “Right now, the support is not only from UNFPA, but they (i.e., the midwives’ association) have solicited some support from AMREF and Rotary Club of Kampala – and they are now conducting some CPD (Continuous Professional Development) sessions for midwives around the country. They do mentoring, they train midwives on different midwifery processes to improve the standards and the quality of care that midwives provide. They are supporting this CPD across the country and they “put a good image to the midwives.” Sida supports “midwife-led activities” – where the midwives are very key. So, they go in the communities to promote midwifery activities, they talk on radio and TV, they encourage others to become midwives. They do a lot to bring light to the midwifery in Uganda.” 	Interview, UNFPA Uganda staff, May 2021
<ul style="list-style-type: none"> • The IDM was successfully commemorated in May 2018. The function was officiated by the Speaker of Parliament of Uganda. The National Midwives Association was launched during the Commemoration. The Annual National Midwives Symposium was also with Over 350 midwives in attendance. <p>Activities conducted with the UPMA:</p> <ul style="list-style-type: none"> • UPMA with MoH followed up and mentored 20 private midwives and their co-workers at maternity homes for those who received midwifery kits from UNFPA in northern Uganda and Teso regions. Midwives were mentored on EmONC and their role in the community. Findings from the mentorship included: <ul style="list-style-type: none"> • 90 per cent of maternity homes/clinics need remodelling to ensure standards improve privacy and infection prevention. • Three midwives received updates on long-acting contraception and only one had the skill to insert postpartum IUD. • In most health facilities, midwives needed skills for handling emergencies like PPH, neonatal resuscitation and Eclampsia. 	UNFPA Uganda, UNFPA-MoH Annual Workplan Progress Report, 2018
<ul style="list-style-type: none"> • The National Midwives Association was launched during the 2018 IDM, with the theme, midwives leading the way with quality of care. “Good quality maternal health services are those which, among others, are readily accessible; safe, effective, 	MoH Uganda, Report of the International Day of the Midwife 2018, 2018

Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support	
<p>acceptable to potential users and are staffed by technical competent people; provide prompt comprehensive care and/or linkages to other RH services’ provide continuity of care, and where staff are helpful, respectful and non-judgmental.”</p> <p>Recommendations and follow-up actions included:</p> <ul style="list-style-type: none"> • Provide increased funding for midwife training • Maintain close links with Embassy of Sweden to build relationships and ensure continued support for Midwifery Programme • Support the Midwifery Association to ensure functionality and sustainability 	
<ul style="list-style-type: none"> • Networking of midwives from public and private sectors has increased through the National Midwives Association of Uganda (NMAU) platform established in 2018. It is envisaged that NMAU will help in advocacy for the improvement of midwifery programme in the country. UNFPA has continued to support Uganda Private Midwives to deliver SRHR services in the under-served areas in order to increase access to such services. 	UNFPA Uganda, 2018 MHTF Annual Report, 2018
<ul style="list-style-type: none"> • MHTF supports is the IDM, and one of the targets for supporting it, is ensuring that more midwives are recruited during these events, so they can join the associations. “We had challenges in 2020, because the international midwifery day was almost virtual, and we could not access as many midwives as we wanted to. The number of midwives who could join was very limited. That is one thing they need to focus on (more members). Also, getting more funding.” 	Interview, UNFPA Uganda staff, Kampala, May 2021
<p>Promotion of midwifery through IDM commemorations</p> <ul style="list-style-type: none"> • The IDM was commemorated in May in Mbarara District, following a two-day Midwifery Symposium. The Symposium included an exhibition by many partners to share policies, technical documents and reports; good practices in midwifery; innovations; advocacy, IEC materials and policy briefs. The national event ran for a whole week and were concluded with the celebration. The pre-event activities included: radio talk shows on local radios in Mbarara district; community mobilization; provision of reproductive health services in camps; and midwife-led campaigns and activities such as a blood donation drive, midwifery career promotion and a visit to a women’s prison. 	UNFPA Uganda, GoU/UNFPA Country Program Support to MoH 2019 Annual Workplan, 2019
<ul style="list-style-type: none"> • The 2019 IDM was celebrated under the theme “Midwives, defenders of Human Rights.” The MoH with support from UNFPA and in collaboration with the NMAU, the UNMC, stakeholders, and other nursing and midwifery bodies organized the IDM celebrations and its pre-event activities in Mbarara district. • Activities included midwife-led blood drives and career promotion, provision of reproductive health services via camps (family planning, cervical cancer screening), radio talk shows, community mobilization through schools and a film van, advocacy meetings with host district leaders, a midwives’ symposium (with 18 partner exhibits), and the placement of midwifery stories in the media. • Recommendations for future IDMs, include reaching out to more partners, CSOs, ministries and stakeholders to support and participate. 	MoH Uganda, Report of the International Day of the Midwife 2019, 2019
<ul style="list-style-type: none"> • The role of the midwives was acknowledged and appreciated during the IDM, which was successfully celebrated despite the COVID-19 situation with the leadership of the MoH and the Nurses and Midwifery Association of Uganda. A 20-minute documentary has been developed in commemoration of the International Year of the Midwife and it is speaking about midwifery in Uganda supported by UNFPA and the Embassy of Sweden with the MoH at the forefront.” 	UNFPA Uganda, Final Annual Report for MHTF, 2020, pp.3-4

Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support	
<ul style="list-style-type: none"> • The MoH collaborated with UNFPA and other partners to organize the commemoration of midwives amidst the COVID-19 pandemic at Mulago National Specialized Women’s Hospital under the theme, “Midwives with women: Celebrate, demonstrate, mobilize, unite – our time is NOW!” The IDM was virtual, with the aim to advocate for investment in midwives and midwifery nationally. The year 2020 was declared by WHO as the International Year of the Nurse and Midwife. <p>Reported results included:</p> <ul style="list-style-type: none"> • Commitment of support from the Ambassador of Sweden for the Midwifery and maternal health programmes • Midwifery stories broadcast in the media • Recommended/follow-up actions: • Revise the MoH workplan so that midwives from Nursing Department, MoH and NMAU can mentor and celebrate IDM with midwives at lower-level health facilities • Maintain close links with Swedish Embassy to build relationship and continued support • Support and work closely with NMAU to ensure improvement in Midwifery programme and enhance professional image of midwives. 	<p>MoH Uganda, Report of the International Day of the Midwife, 2020, 2020.</p>
<ul style="list-style-type: none"> • The IDM was celebrated virtually and was preceded by Zoom meetings, TV and radio talk shows which focused on the role and importance of midwives, especially during the COVID-19 pandemic. Media stories on midwives were placed in different national newspapers: • Midwives grapple with COVID-19 while ensuring safe delivery (New Vision Newspaper: 5th May 2020): https://www.newvision.co.ug/new_vision/news/1518493/midwives-grapple-covid-19-ensuring-safe-delivery • Uganda celebrates nurses and midwives working amidst COVID-19 scare (UBC TV, 6th May 2020): https://www.youtube.com/watch?v=1YYeJuMRwkE&feature=youtu.be • Minister commends midwives for being brave amidst COVID-19 (New Vision, 9th May, 2020): https://www.newvision.co.ug/new_vision/news/1518612/minister-commends-midwives-brave-amidst-covid-19 • Safe births amidst COVID-19: Midwives are saving lives of mothers and babies (UNFPA Uganda Website): https://uganda.unfpa.org/en/news/safe-births-amidst-covid-19-midwives-are-saving-lives-mothers-and-babies • Standing in solidarity with midwives in the time of COVID-19: Minister of State for Primary Healthcare, the Ambassador of Sweden and UNFPA Representative Visit Midwives on Duty (UNFPA Uganda Website): https://uganda.unfpa.org/en/news/standing-solidarity-midwives-time-covid-19-minister-state-primary-healthcare-ambassador-sweden • Mobile App helps midwives support safe delivery among teenage mothers during the COVID-19 pandemic (UNFPA Uganda Website): https://uganda.unfpa.org/en/news/mobile-app-helps-midwives-support-safe-delivery-among-teenage-mothers-during-covid-19-pandemic • Ministerial Press Statement on the International Day of the Midwife: www.health.go.ug • An additional 72 midwives were enrolled as members of NMAU during IDM celebrations at various health facilities, bringing the total number of members to 326. 	<p>UNFPA Uganda, MHTF Mid-Year Report, 2020</p>

Assumption 1.3: Efforts to strengthen the capacity of midwifery organisations result in enhanced professionalization of midwives and increased opportunities for continuous professional education and career progression and support	
<ul style="list-style-type: none"> The IDM was successfully held in Jinja District on 5th May 2018. The function was officiated by the Speaker of Parliament of Uganda and His Excellence the Ambassador of Sweden. Other key stakeholders included WHO, Midwifery Professional districts and CSOs. The speaker of parliament also launched the Midwifery association constitution and called on partners to support the noble cause expanding midwifery programmes since this is critical in reducing maternal and newborn morbidities and deaths. The Annual National Midwives Symposium was also successfully held as a pre-event for the Midwifery Day and over 350 midwives attended the conference. This provides an opportunity for midwives to speak with one voice for strengthening midwifery services in the country. Using this platform, they advocate for better living and working and enabling conditions. The young generation of midwives are mentored and engaged in leadership at all levels. Participation of midwives in global and regional events was not supported in 2018 due to limited funds. The total cost of the IDM, including the symposium was USD 32,000. 	UNFPA Uganda, 2018 MHTF Annual Report, 2018
<ul style="list-style-type: none"> Conducting these annual days is a “political deal, a landmark, to show him or herself, similar to producing lots of t-shirts! If you repeat the same message every day, and every year, it means that this is implementation. It is a necessary evil – in the sense that we are not NGO or bilateral – we cannot say “stop this”, we do not have any choice.” 	Interview, UNFPA Uganda staff, Kampala, May 2021

Area of Investigation 2: Emergency obstetric and newborn care	
Evaluation Question 2: To what extent has the MHTF supported ministries of health to design, strengthen and scale-up a national network of basic level and referral maternity facilities staffed with skilled health personnel and capable of providing quality sexual and reproductive health services as well as maternal and newborn care, including EmONC?	
Sub-Questions:	
a) How and to what extent does the MHTF contribute to the development of nationally aligned strategies and policies to define and monitor the national network of EmONC facilities and strengthen referral linkages? b) To what extent has the MHTF contributed to the strengthened functioning of the national network of EmONC facilities to provide equitable, accountable, and quality SRHR services including through QI and monitoring processes? c) To what extent does the MHTF contribute to strengthened capacities of skilled health personnel in EmONC facilities to provide equitable, accountable, and quality SRHR services?	
Evaluation Criteria	<i>Relevance, effectiveness, efficiency, sustainability</i>
Rationale	Women and newborns are at high risk of death and morbidity during labour, childbirth and the first week after birth. UNFPA activities to promote evidence-based policies and plans in support of increased access to equitable, accountable, and quality EmONC services aim to reduce maternal and newborn mortality and morbidity. UNFPA is building on lessons from previous MHTF phases to support planning and monitoring of the national network of EmONC facilities, strengthened QI processes, scale-up in additional countries, and to strengthen integration via further support to post-partum and post-abortion family planning and cervical cancer prevention.

Assumption 2.1: MHTF efforts at global, regional and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC	
Indicators:	
<ul style="list-style-type: none"> • Alignment between global and regional evidence-based guidance and national strategies for defining, monitoring and scaling- up of strengthened EmONC and SRHR services • Examples of MHTF advocacy and policy dialogue and partner coordination in support of national plans designed to strengthen and scale-up quality SRHR and MNH, including EmONC services within a well-defined network of facilities • Trends over time in proportion of population covered by a functioning EmONC network of facilities (within 2 hours travel time) • MHTF workplans include application of lessons learned (knowledge management) from prior phases to improve quality and support scale-up of services within countries and to new countries. • Views and experience of health authorities and partner institutions at global, national and sub-national level regarding relevance, effectiveness and synergy between other UNFPA interventions and MHTF efforts to address EmONC and support integrated SRHR and MNH services • Views and experience of health authorities and partner institutions regarding UNFPA leadership on core principles of equity in access, quality of care, accountability, and on principles related to human rights and gender equality. 	
Observations	Sources of Evidence
Note: Most of the UNFPA inputs related to quality improvement (see assumption 2.1).	
<ul style="list-style-type: none"> • “Regarding EMONC, while it did not look like we invested a lot in EMONC and upstream work, there was a lot of investment in the humanitarian response.” • “I want to clarify that on EMONC, of course in 2020, we include funds for EMONC in the (MHTF) work plan but was part of the money that was reprogrammed when we were responding to COVID-19. In 2021, we have some more funds to monitor/mentor EMONC, so there are some funds in the 2021 work plan. 	Group discussion, UNFPA Uganda staff, May 2021
<ul style="list-style-type: none"> • The EmONC network model promoted by MHTF is focused on accessibility modelling utilizing EmONC network process software developed in partnership with the University of Geneva. The effort includes building capacity in countries to use GIS software and working closely with MoHs to institutionalise it and work through the four phases of network development. • UNFPA Uganda decided not to use the network approach for EmONC. 	Interview, Global key informant, September 2021
<ul style="list-style-type: none"> • When asked if the CO received information or guidance on the EMONC “network” approach, the response was negative. • “I do not remember when we last received funding for EMONC. We have received funding for the other 3 areas – it is only this year that we have received EMONC support again, but overall, EMONC has not received much funding.” • “Of course, we are the ones who make the work plan – and when we look at the funding, we prioritise what is most important. We did put some activities on EMONC, but I cannot remember why the funding for EMONC did not come through. But also if we look at other areas as fistula, MPDSR and midwifery also contribute to EMONC. • We also put some EMONC activities in the Sida proposal. • One of the ANSWER programme IPs, Marie Stopes, did a rapid assessment of needs in the facilities – so they conducted a BEMONC training because it was found to be a great gap. They were addressing the demand side – but they needed to make sure that quality services were there. Also under the ANSWER programme, there is an element of coaching.” 	Interview, UNFPA Uganda staff, Kampala, May 2021

Assumption 2.1: MHTF efforts at global, regional and national level in evidence-based advocacy, policy dialogue, coordination, and knowledge management lead to national plans for a well-functioning national network of EmONC facilities with the capacity to provide quality SRHR services and maternal and newborn care, including EmONC	
<ul style="list-style-type: none"> • This model is an innovative approach to develop a national network of referral maternities accessible by the population and able to manage all obstetric and neonatal complications with quality of care. • It supports the reorganization of the health system through the identification and selection of a limited number of referral maternities (EmONC) on which to focus resources to ensure the facilities are able to cover the population within one or two hours of travel time. • The model is built on new programmatic approaches to strengthen routine management and use of maternal, newborn, and reproductive health data and leverages the concepts of implementation research to improve quality of care in referral maternity facilities. 	<p>UNFPA, Implementation manual for developing a national network of maternity units: Improving emergency obstetric and newborn care (EmONC), 2020</p>
<ul style="list-style-type: none"> • One of the strategic interventions under UNFPA CP8 for increasing the national and district capacity to deliver comprehensive high quality maternal health services were to: • Functionalise Health Centre (HC) IVs • Provide the basic amenities and infrastructure to support provision of EmONC services in 25 UNFPA target districts with equipment as per MoH standards • Provide technical support for continuous quality improvement of SRH services with special focus on 34 target districts • Enhance performance of midwifery services in underserved areas. <p>Achievements (percentage):</p> <ul style="list-style-type: none"> • 8 per cent of HC IIIs with capacity to provide EmONC (below target by 72 per cent) • 7 per cent of HC IVs with capacity to provide EmONC (below target by 53 per cent) • 7 per cent of hospitals with capacity to provide EmONC (below target by 93 per cent) • “UNFPA invested more in upstream activities such as support to MoH in formulation of SRH policies and guidelines than in downstream ones such health staffing, equipping health facilities, setting up blood transfusion facilities, which would have had more direct impact on the capacity for EmONC. For significant improvement of EmONC provision to happen, UNFPA needs to invest in advocacy in the following game changers: • Strong advocacy to MoH and DLGs for the recruitment and deployment of critical staff cadres to those HC ^{[[]]}IVs without - anaesthetists, laboratory attendants /technicians, theatre attendants, medical officers ^{[[]]} • Upgrading of some HC IIIs into HC IVs especially in the hard-to-reach areas to improve coverage • Provision of essential medical equipment items and especially those directly related to EmONC • Setting up of a sustainable ambulance referral system to allow mothers with complications to be referred from lower-level HCs to higher ones” (p.54) 	<p>GoU and UNFPA, UNFPA 8th Country Programme, 2016-2020 Evaluation Report, 2020</p>
<p>The following are entries for EmONC activities under the 2019 MHTF annual report:</p> <ul style="list-style-type: none"> • “UNFPA supported the MoH to develop the National Policy for Sexual Reproductive Health and Rights that was approved by Top management at MoH, a Certificate of Financial Implications (CFI) for the National Policy Guidelines for SRHR has been issued by the Ministry of Finance, Planning and Economic Development and following completion of the Regulatory Impact Assessment (RIA), the policy is now ready for presentation to Cabinet for approval and this will be shared after approval. 	<p>UNFPA Uganda, 2019 Annual MHTF Report, 2019</p>

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<p>UNFPA is working with relevant departments and division, particularly the Department of Health Sector Strategy and Policy, and the Division of Reproductive and Infant Health to expedite the process of submitting the SRHR policy to the Cabinet.</p> <ul style="list-style-type: none"> UNFPA supported the RMNCAH Assembly, the 3rd National Family Planning Conference, and Network of African Parliamentary Committees on Health (NEAPACOH) conference, and resolutions and commitments were made on how to advance the RMNCAH agenda. For example, NEAPACOH committed itself towards increasing advocacy for domestic financing for SRH/FP including the fast-tracking enactment and implementation of the National Health Insurance Scheme (NHIS) Bill, which has now been approved by cabinet.” “UNFPA with support from Governments of Netherlands and Austria is going to scale up Quality Improvement approaches (CQI) to enhance achievement of better health outcomes and greater efficiency in the delivery of quality services to address gaps impeding delivery of quality ANC, labour and delivery, and newborn care services in the target districts.” (p.4) 	
<p>The following is the entry for EmONC in the MHTF 2018 annual report:</p> <ul style="list-style-type: none"> “The National Policy for Sexual Reproductive Health and Rights which has been under review was approved by top management of MoH. However, the element of delivering family planning services to adolescents/young people under 15 years of age still poses a challenge. The Uganda Demographic Health Survey (UDHS) 2016 results showed that Uganda still has high teenage pregnancy rate at (25%) and 48% of Uganda’s population is aged 0-14 years. As the country strives to improve family planning utilization and uptake, the sexually active adolescents should be brought in context to avoid associated consequences. The MoH in partnership with UNFPA has trained Trainer of trainers from MoH, districts, implementing partners (IPs) both in humanitarian and development in Minimum Initial Service Package (MISP) for SRH and clinical care prevention and management of GBV survivors. The training underscored the need for integration and provision of quality Emergency Obstetric and Neonatal care services to reduce on maternal and newborn morbidity and mortality. Advocacy for inclusion of MISP in pre-service training in curriculum of Medical schools, Tutor colleges and midwifery schools was done through meetings with the heads of training in Ministry of Education, tutor college principals and Deans of the schools of Health sciences, Public health in Makerere University.” p.3 	<p>UNFPA Uganda, 2018 Annual MHTF Report, 2018.</p>
<ul style="list-style-type: none"> This assessment was supported by Sida to generate baseline information on emergency obstetric and neonatal interventions for use in developing district-specific action plans. The assessment was conducted in 25 targeted districts in the Western, Eastern, Northern, Karamoja and West Nile regions of Uganda. <p>Findings include:</p> <ul style="list-style-type: none"> The assessment showed that the overall met need for EmONC in the targeted districts in the past 12 months was only 1.55 per cent in surveyed facilities. Met need is defined as the proportion of women with obstetric complications treated in EmONC facilities (Recommended minimum: 100% - estimated as 15% of expected births) The overall service availability was universal for antenatal, normal delivery and postnatal care. However, there was limited availability equipment, supplies and skilled birth attendants to address emergencies during labour and delivery. In addition, the referral system was hobbled by non-functioning ambulances and communication difficulties between the HC IV and lower-level Health facilities. 	<p>UNFPA and MoH Uganda, Assessment of quality and coverage of EmONC services in 25 targeted districts, 2017</p>

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<ul style="list-style-type: none"> The use of partograph to monitor and manage labour was high but with low adherence to the partograph use standards. Infection prevention remains a challenge due to low availability of functioning sterilization equipment at all levels of healthcare. On the plus side, there was high prevalence of thermal protection of the newborn among facilities. “Bottlenecks to achieving effective coverage of high impact Maternal Newborn Health interventions at scale have been identified in the 2016 Reproductive Maternal Newborn Child Adolescent Health (RMNCAH) Investment case. These include leadership, human resources, service delivery, information systems, supply chain and economic access among others. Therefore, urgent effort is needed to first tackle the immediate causes of death for the majority of women and newborns, while putting in place longer-term efforts to strengthen the health system and working on the social determinants that majorly lie outside the health sector.” (p.2) 	
<ul style="list-style-type: none"> Sida has funded UNFPA to implement MNH activities as part of an integrated SRHR programme, in Phase 1: 2013-2014, and Phase II: 2015-2017. Support for MNH activities was supposed to be phased-out in Phase II but was then carried-over in the new GBV-focused joint UNFPA-UN Women programme that started in 2018. 	Interview with bilateral donor, Kampala, May 2021

Assumption 2.2: MHTF inputs at national and sub-national level regarding the use of QI processes, tools and data collection are consistent with improved monitoring and quality of SRHR services and maternal and newborn care, including EmONC	
Indicators:	
<ul style="list-style-type: none"> Examples of MHTF efforts to strengthen QI processes, tools and data collection at national and sub-national level Views of health officers at national and sub-national level in geographies supported by UNFPA, which confirm implementation of QI monitoring on a regular basis and the utilisation of findings to support improvements in services Examples of how QI efforts incorporate MHTF core principles, human rights and gender equality within supervision and mentorship Views of health officials, including facility managers, providers, and community members regarding how SRHR and MNH services, including EmONC services, are monitored to ensure quality Availability of plans to sustain (institutionalize) UNFPA-supported QI processes within national performance and supervision systems. 	
Observations	Sources of Evidence
<p>Support for national strategies to advance quality improvement approaches in maternal care:</p> <ul style="list-style-type: none"> UNFPA supported implementation of the quality improvement approaches both at national and sub-national to address gaps in the quality of ANC, labour and delivery, postnatal and newborn care services. At national level, UNFPA supported revision of the National Quality Improvement Strategy and Framework 2020- 2025 and the finalization and launch of the Patient’s charter on the World Patient’s Safety Day commemoration. UNFPA also supported MoH to update the QI training packages and trained 50 national and regional trainers. Training was provided to 1,230 health personnel in quality improvement in maternal health, family planning, post abortion care and SGBV screening and treatment. Additionally, 521 health personnel have been trained on data management, capture and analysis in relation to QI. (Support for these activities came from the Netherlands and Austria.) 	UNFPA Uganda, Final Annual Report for MHTF, 2020

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<ul style="list-style-type: none"> The quality improvement framework and strategic plan for 2016-2020 was revised with support from USAID ASSIST project based on an evaluation that identified lessons from implementation of the previous framework and plan. The goal of the framework is to: Strengthen leadership capacity and support for QI Strengthen documentation, reporting and sharing of QI data and processes Strengthen patient/client-centred care Improve compliance by facilities of service standards Strengthen organizational capacity for QI implementation Promote innovation The framework describes the content of care (norms, standards, protocols, guidelines) and the process of care (QI approaches and the cycle of learning and improvement) to achieve the outcome of improved quality of care. Interventions supported by the strategy include the iterative cycle of improvement (Plan, do, study, act cycle) and 5S, a methodology that supports a clean, uncluttered, safe and well-organized workspace as a fundamental background for CQI. Challenges related to implementing QI approaches include the following: <ul style="list-style-type: none"> Insufficient evidence of extent of harmful care (which is thought to be widespread) Political and communication challenges in addressing harmful and wasteful care QI approaches are donor-dependent QI approaches are disease-specific and mainly in the HIV/AIDS space (related to donor dependency). 	MoH Uganda, Health sector quality improvement framework and strategic plan, 2015/16-2019/2020, 2016
<ul style="list-style-type: none"> UNFPA supports quality of care, especially in EMONC facilities. For example, during training they support health care workers on how to use the partogram and they support data quality review meetings to improve the accuracy of data (MPDSR). UNFPA efforts are aligned to the national CQI framework. The current model of UNFPA supporting strategically the MoH and the districts to conduct activities at the operational level is commendable. "I strongly think that this combination is an area where they can really do well, across the whole area of SRHR, FP, EMONC. They have not done much under EMONC, but they can also do some, e.g. procuring ambulances." 	Interview, MoH official, Kampala, May 2021
<p>Supportive supervision inputs (funded through non-MHTF sources)</p> <ul style="list-style-type: none"> Supportive supervision is led by the ADHO (Assistant DHO), supported by MSU through spot checks, as they accompany supervisors on all visits to facilities. During spot checks, MSU uses a check list which is based on the national tools, but also include specific indicators for the ANSWER project (i.e., related to the voucher programme). ☒ MSU noted that during the supervisory visit, some facilities requested the districts to provide equipment. The procurement process is through the National Medical Store; districts lobby and request NMS to send equipment. If they cannot provide the equipment, different partners may provide support, e.g., equipment for deliveries and post abortion care. If something is missing, it is brought up during the quarterly DHO meetings, which are attended by partners working the district. UNFPA has not yet informed MSU if and who is going to provide the equipment and commodities requested. 	Interview, NGO national staff, Arua District, Uganda, May 2021

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<ul style="list-style-type: none"> MSU conducts supportive supervision with the DHO on a quarterly basis. They also do Joint Clinical Quality Audits (different from CQI). The Clinical Quality Audits are a “top-down” tool to check services against clinical guidelines and standards. [2] 	Interview, UNFPA Uganda staff, May 2021
<p>Quality of care issues at service delivery level</p> <ul style="list-style-type: none"> “At the facility level, we have issues with quality of care in EmONC. We have inadequate staff and skills; equipment and supplies are also a gap. Sometimes we have deaths because of lack of equipment and supplies. We have issues of surgical skills for C-sections. At HCIV facilities, the medical officers do not always have the skills as they have not been properly developed at school. We also have a huge gap of anaesthetists, especially at HCIV level where women need them the most. Taking proxy of delivering C-sections and blood transfusion – we are still quite low.” <p>Quality of care, other issues:</p> <ul style="list-style-type: none"> Lack of transport/ambulance services. Because in many places, the client has to walk to reach the referral facility, because vehicles/ambulances are not available. There are many deaths in transit, and on arrival etc. Issues with the working environment, infrastructure, equipment and commodities Weak diagnostics (skills gaps). Some complications could have been detected earlier – but discovered too late. Local customs: use of local herbs to manage pregnancy and complications. Issues of absenteeism and inadequate numbers of health workers. 	Interview, MoH national staff, Kampala, May 2021
<ul style="list-style-type: none"> Providers were asked about activities to improve the quality of services. The following points were made: In family planning, mentorship has been conducted by IRC (International Rescue Committee). One of the district trainers/mentors (there are two per district) is based in this facility. The ADHO conducts supervision visits on a monthly basis. There is no regular internal supervision/mentoring within the facility. Ways to improve quality are discussed during monthly review meetings in the MCH department. No other QI approaches were mentioned. When asked about data for decision-making, trends in service delivery numbers were noted (e.g., increases in deliveries, abortions, premature deliveries). 	Interview, MoH service providers, Lawmo District, Uganda, May 2021

Assumption 2.3: UNFPA inputs at national and sub-national level to address gaps in capacity of skilled birth attendants in EmONC facilities results in improved quality of integrated SRHR services and maternal and newborn care, including EmONC	
<p>Indicators:</p> <ul style="list-style-type: none"> Demonstrable improvements in health care provider capacity (as defined by the COM-B²⁷ model of behaviour change) in the MHTF-supported facilities to deliver quality integrated SRHR services and MNH care in accordance with service standards and guidelines Trends in the proportion of functioning BEmONC and EmONC facilities within the national network Views of implementing partners (national health officials, NGOs, CSOs, community leaders and individuals) regarding effectiveness of capacity development efforts by UNFPA and how it has improved the performance of skilled birth attendants 	

²⁷ The COM-B model of behaviour change (Mayne 2016) will be used to assess provider capacity based on three necessary conditions: 1) capability (necessary knowledge, skills, and attitudes to deliver quality care), 2) opportunity (having the necessary infrastructure, equipment, supplies and tools to deliver quality care), and 3) motivation (internal cognitive and emotional processes related to willingness and perceived personal benefit of providing good quality of services).

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<ul style="list-style-type: none"> Alignment of UNFPA capacity development inputs with MHTF core principles (Equity in access, quality of care and accountability; plus, principles of human rights and gender equality). 	
Observations	Sources of Evidence
<p>Strengthening capacity at tertiary level</p> <ul style="list-style-type: none"> Kawempe National Referral hospital is a tertiary hospital in Kampala, serving a population of 4.5 million people. Annually there are 30,000 deliveries at the hospital and an average of 80 – 100 babies born daily. The tertiary neonatal unit has 81 beds and is organized into four compartments, i.e., an intensive care unit (10 beds), “high care area: (20 beds), a stable ward (50 beds), namely: Intensive care unit -10 beds, High care area 20 beds, and stable ward (50) for pre-terms and term babies. UNFPA supported a consultancy to improve newborn care through the development of a QI plan. The following activities were undertaken: <ul style="list-style-type: none"> A quality assessment of services covered in the NICU, including gaps in skills and knowledge among health workers Compile and orient staff on protocols and management guidelines for common conditions Develop a QI plan Guide the NICU team to reorganize the NICU for better patient flow and service delivery Conduct drill sessions and mentorship on key critical emergency interventions for the NICU team. Key challenges identified in the inception report included: <ul style="list-style-type: none"> While the infrastructure and basic equipment are available, the patient numbers are very high. For example, there are two babies per incubator, increasing risk of infection. Equipment exists (ventilators, CPAPS, oxygen ports, monitors and radiant warmers), but not in relation to the numbers of patients. There are not enough nurses and doctors available relative to the number of patients. Protocol books are available, but not displayed nor uniformly used. There is a need to harmonize and train staff on use of protocols to standardize care. Skills need improvement for “management of respiratory distress from delivery room to NICU, neonatal resuscitation, feeds and fluid management, infection control and antibiotic stewardship, neonatal ventilation and surfactant administration.” (p. 15). There is also the need to “functionalize the lower health units to reduce referrals to Kawempe so as to decrease the burden of sick newborns admitted there.” (p. 18) 	<p>V. Nakibuuka, Inception Report, Kawempe National Referral Hospital, Uganda, 2020</p>
<ul style="list-style-type: none"> UNFPA has supported the renovation of the neonatal special care unit at the Kawempe national referral hospital (together with UMTN, UNICEF and several other partners. UNFPA contributed both technically and financially, mainly with remodelling and equipment. For maternal health, UNFPA also procured delivery beds, operating beds and a VVF repair bed (the latter still has not been delivered), which helped improve EMONC services according to the interviewee. Kawempe national referral hospital has serious HRH gaps, including lack of midwives and anaesthetists, and request UNFPA for support in this area. “We ask UNFPA to continue supporting the process of decongesting Kawempe and in printing our CEmONC protocols, tools, etc. Our HR is not adequate in numbers and if they can cover the gap for 1-2 years until the government has recruited. In Mulago, I saw 30 midwives and nurses; but at Kawempe we need 50 as we have a high turnover 	<p>Interview, MoH service provider, Kampala, May 2021</p>

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<p>of patients. There is no revenue collection, no increase in wage, we cannot recruit anymore, got worse with COVID-19. We had been given green light to review of staffing structure, to understand which critical cadres we needed, and we did that -it was prior to COVID-19 – but as we were midway in the process, we were informed that there was no wage to take on these new cadres, so everything was put on hold. It was probably because of low revenue collection due to the total lock of our country.”</p>	
<p>MoH perspectives on gaps and challenges in EmONC and MNH</p> <ul style="list-style-type: none"> • Largely there is a skills gap among health workers. UNFPA support is appreciated, especially to address the gap in update of long-acting reversible contraception (LARCs). “We really undertake a rights-based approach with family planning. We are not promoting some methods over others. So, with UNFPA we have done methods-mix training of HCW.” • With ANC, there is late attendance with many women forgoing ANC visit during the first trimester. There have been some studies undertaken, not only by UNFPA but also other agencies like USAID. “We see about 20 per cent for the first ANC in first trimester. For the 4 ANC, it is also less than 50 per cent but there have been some improvements over the years. Slow progress.” • Regarding labour and delivery, many mothers and babies are lost due to PPH, close to 50 per cent of maternal deaths in country. There has been a lot of support from UNFPA has been around building skills of health workers in EMONC. But PPH remains an issue The largest gap was the skills, but next in the line, are issues of equipment, especially at the high-level facilities. • In addition to skills and equipment gaps, the other issue is demand creation at the community. “If we are only addressing the supply side, where we’re already doing a lot, a lot of services are already available, but demand and access, and then we have COVID-19.” • There is low uptake of PNC services. There are few entries when the PNC registries are looked at. Sometimes the health worker does not pay a lot of attention to the women who come for PNC, especially those who have no complaints. • The last key issue is inadequate HRH, especially the critical cadres, i.e., anaesthesia officers and the medical officers. “We have issues with our staffing norms. A facility that needs four doctors, will still only provide two doctors, based on staffing norms 20 years ago. MoH is currently revising staffing norms because the population of Uganda has almost tripled since the norms were development. A facility has maybe only two medical officers according to staffing norms – but they really need four to five. So even if it says “all positions filled” – it means in reality that it is not filled; it is still a gap of three. They have begun with the revision of staffing norms – starting at the RRH. The RRH are overwhelmed with very many clients, but the staffing is so thin. We hope that at the end of this process, we will have more health workers, especially the critical cadres, provided for within health facility structures.” • Commodities remains an issue, although the MoH is appreciative of the support from UNFPA and USAID, and UNICEF for child health medicines. • For the newborn, the equipment and supplies are an issue for newborn resuscitation/Helping Babies Breathe. Many facilities lack ambubags, and masks are not available in most places. “We have so many HC III, but often we give equipment etc. to HCVI and hospitals, partners have tendency to focus on high volume facilities – especially those who are focusing on numbers/targets – e.g. USAID. But many HCIII conduct many, many deliveries – but partners focus on high volume. But we 	<p>Interview, MoH official, Kampala, May 2021</p>

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<p>still need the equipment at all HCIII – there are more than 2000 HCIII. They say “look for 20% of facilities who give you 80% results.”</p> <ul style="list-style-type: none"> • There is a need to continue and strengthen capacity building, through on-site mentorships, as opposed to classroom teaching, to ensure that a critical mass of health care workers receives targeted MPDSR, EMONC, adolescent SRHR and GBV. “We’ve also had district-based learning sessions on ASRHR and GBV, where low and high performing districts come together to review, discuss and compare. UNFPA supports training of health care workers in FP and method-mix for GBV survivor. For as much as we have been doing method mix training – but the gaps are in LARCs. The insertion of IUD is a key gap – much of our practicum was focusing on the IUD insertion – both postpartum and interval/general IUDs. The funding was more for GBV aspects, but we (MoH together with UNFPA) made it more comprehensive – we used Sida funding (through UNFPA) for the trainings on method mix including EMERGENCY funding – specially targeting GBV survivors – but also other women are coming to the health facilities and will benefit from the improved FP services.” 	
<p>Challenges/gaps in EmONC (HCIV) and BEmONC (HCIII) facilities:</p> <ul style="list-style-type: none"> • “There are still gaps in functionalizing level four health facilities to address emergency obstetric complications as well conduct caesarean sections and reduce on the referral burden to the regional and referral hospitals since this requires a concerted effort from different sectors including water and energy. The CO continues to invest in capacity building through training and mentorship of human resources in EmONC and quality improvement as well as providing equipment where possible.” 	UNFPA Uganda, Final Report for MHTF, 2020, p.20
<ul style="list-style-type: none"> • “Facility-based deliveries have been used as a proxy for skilled birth attendance. The assumption for the use of the proportion of health facility deliveries as a proxy for skilled birth attendance is that the birth attendants at health facilities have the necessary competent skills to provide care during childbirth and are trained, accredited and skilled health professionals (such as midwives, clinical officers, doctors, or nurses). The skilled health professional must also be supported by appropriate standards of practice (education, training and regulation), and operates within an enabling environment (a functioning health system, comprising six building blocks). The proportion of facility-based deliveries improved from 47 per cent in 2016 to 58 per cent in 2019 in UNFPA-supported districts, which indicated that mothers were continuing to come to health facilities to deliver. <p>However, the quality of obstetric care might have been below the expected standard, given that the proportion of health facilities in the target districts which were able to offer all the signal functions of EmONC was 8 per cent for HC IIIs and 7 per cent for HC IVs and hospitals compared to the targets of 70 per cent of HC IIIs, 60 per cent of HC IVs and 100 per cent of hospitals. As afore mentioned, the critical factors undermining the ability of health facilities to offer all signal functions of the EmONC were inadequate staffing level of critical cadres, inadequate provision of the basic amenities and infrastructure.”</p>	UNFPA Uganda, GoU/UNFPA 8 th Country Programme 2016-2020 Evaluation Report, 2020, p.37
<ul style="list-style-type: none"> • UNFPA has focused on EMONC, ambulance/referral systems, and supporting and deploying midwives in hard-to-reach areas. UNFPA has also taken the lead on MPDSR (together with WHO). The key issues and gaps influencing MNH in Uganda are low health-seeking behaviours, lack of quantity and quality of skilled staff (including surgical skills and anaesthetists), poor logistics and supply chain management system, affecting availability of drugs and commodities including blood, lack of equipment and ambulances/effective referral system. Most health facilities do not have the equipment to take care of 	Interview, MoH national staff, Kampala, May 2021

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<p>premature babies (note: see interview notes from CEmONC site in Lamwo – equipment was available, but staff did not know how to use it).</p> <ul style="list-style-type: none"> • Only 60 per cent of mothers attend all four ANC visits. For at least 1 visit (not first trimester), the percentage is high, at 98 per cent. The mortality is still high – in intrapartum care – is classically high. Seventy-three per cent of women deliver in health facilities, there is the issue of delay in reaching the health facility, sometimes because of infrastructure, sometimes due to distance. “Still at community level, we have myths and misconceptions, and people preferring using traditional birth attendance. They are at near reach, but they sometimes also feel, that they may not get so much from the health facility – it may not be any different than delivering with their traditional birth attendants. They complain about lack of staff at the health facilities, and the environments at the health facilities, e.g. there are lack of medicines, and when they are asked to buy medicines themselves, they think, why go there, if I have to pay for these drugs anyway? We had issues with bad attitudes of providers towards women delivering, bad treatment, but I see that reducing (improvement). We have a call centre here at MoH where people can report about those “not very nice experiences”, and that is how we get those reports. Sometimes, also, they do not find a midwife, so next time, they will not try to go there.” • In terms of the EmONC signal functions: Only 71 per cent of HCVI (CEmONC sites) perform C-sections due to lack of skills and/or infrastructure/equipment. According to the guidelines, midwives are not allowed to perform “assisted deliveries” although it is one of the key BEmONC functions supposed to be performed at every HCIII (and there is no medical doctor at HCIII). • In the national standards for EmONC, “assisted delivery” is a key signal function, including at HCIII facilities (i.e., BEmONC sites). But the health worker (midwife) who is at HCIII is not mandated by their scope of practice to do assisted delivery. There is no medical officer/doctor at HCIII. Maybe a manual extraction can be managed at that level (HCIII), but they have to refer to the next level HCVI for assisted delivery. It is a policy issue. This means that in any HCIII (BEmONC site), they can only perform four out of the five basic signal functions. 	
<ul style="list-style-type: none"> • UNFPA is making a significant contribution to ensuring the functionality of BEmONC and CEmONC facilities in the sub-region by supporting equipment, recruitment and training. Secondly, UNFPA supports strategies to increase referrals and access for refugee and host communities, including ambulance services, demand creation, pregnancy mapping and vouchers (i.e. identifying pregnant girls and women and referring them to the health facilities). Thirdly, UNFPA supports the MPDSR process by providing funds and technical assistance to strengthen functionality of the MPDSR committees at facility and district level. While support for HR/equipment/ambulances seems to have been going on for a while, the MPDSR, vouchers and EMONC training seem to have started only in 2020, as the large new ANSWER/Netherlands programme was launched. 	<p>Interview, UNFPA national staff, Uganda, May 2021</p>
<p>Facility staff perspectives on challenges/gaps in MNH service delivery</p> <ul style="list-style-type: none"> • Facility level staff noted there are only two midwives and a nurse trained in BEmONC to work in ANC, family planning, labour and delivery, EID (exposed infant diagnosis), and young child clinic/immunizations across the MCH department. • The referral system is challenged: some mothers decline to be referred because they do not have relatives where they would be going. Transport home is an issue. The ambulance will take them, but they have to use their own means to return home. 	<p>Interview, MoH service providers, Lawmo District, Uganda, May 2021</p>

Assumption 2.3: UNFPA inputs at national and sub-national level to address gaps in capacity of skilled birth attendants in EmONC facilities results in improved quality of integrated SRHR services and maternal and newborn care, including EmONC	
<ul style="list-style-type: none"> • Gaps at the facility include: the theatre is not functional and there is not an ultrasound machine (need to refer to the main hospital in Kigtum centre; but only 3 or 4 out of ten women will go). “So, we end up misdiagnosing, because we recently had undiagnosed twins – it happens once in a while - it is only when they come into labour that we realise.” 	
<p>Service capacity-building efforts (non-MHTF funded)</p> <ul style="list-style-type: none"> • Marie Stopes-Uganda (MSU) receives support from UNFPA via the Netherlands-funded ANSWER project, starting in late 2020 for capacity building in EmONC and MPDSR and demand-generation/access activities (via pregnancy mapping and a voucher programme for adolescents) in the West Nile and Acholi Sub-Region (Lamwo district is in Acholi). • A competency assessment for midwives was conducted to assess level of knowledge and skills in EmONC. Subsequently, EmONC training and mentorship were started in late 2020. • The assessment also identified gaps in equipment and materials, which were communicated to UNFPA (as MSU does not have a budget for equipment/materials, and it can be covered by other funding sources, e.g. Japanese and Emergency funds). • “That is how we started training for all 14 districts targeted by ANSWER including Lamwo district. The competence assessment was general, but we had interest in EMONC services. We used the MoH assessment tools, but incorporated additional questions, after consultation with the MoH because we were interested in assessing the knowledge and skills for providers. They allowed us to use our (Marie Stopes) competency tool as well, as the MoH tools were too broad. Our Marie Stopes assessment tool is more focused, and we assessed: ANC, PPH, infection prevention, newborn resuscitation, hypertensive disorders in pregnancy, family planning reversible LARC methods (PP-IUD).” • The MSU coordinator indicated that they integrate family planning messages and services in EMONC training: “We cannot do EMONC without doing family planning, for example, PFP”. • MSU make efforts to strengthen the institutional sustainability of the interventions, e.g. by selecting two (senior) district health care providers to become the lead mentors, i.e. responsible for supervision, mentorship of facilities etc. When the project ends, these two mentors will have the capacity to continue to lead the mentoring and supervision in the district. Three weeks after the training, MSU conducted on-site mentorship by the trainers who are national trainers/mentors from MoH. Before training, MSU asked the districts to identify two district trainers to support trainings and mentorship for purpose of sustainability. “Because projects come and go – and we want to build district capacity which can remain even when we leave again.” 	<p>Interview, NGO national staff, Arua District, Uganda, May 2021</p>

Area of Investigation 3: Maternal and perinatal death surveillance and response

Evaluation Question 3: To what extent has the MHTF contributed to firmly establish the main components of the MPDSR programme (guidelines and tools, mandatory notification, costed national plan); to support its implementation at national scale; and to increase the notifications of maternal deaths and strengthen the quality of maternal death reviews and implementation of the “response” component?

Sub-questions:

- a) How, where and to what extent has the MHTF contributed to the establishment and scale-up of MPDSR?
- b) To what extent has MHTF support contributed to sustained or increased quality and credibility of MPDSR as evidenced by increased notification of maternal deaths among other features?
- c) Where and how has MHTF contributed to service and systems improvements as a result of MPDSR findings?

Evaluation Criteria	<i>Relevance, effectiveness, sustainability</i>
Rationale	MPDSR efforts intensified globally following the publication of technical guidance by WHO in 2013. By 2015, over 76 countries adopted policies for the systematic review of maternal deaths, and 41 and 56 countries have adopted policies for review of stillbirths and neonatal deaths, respectively. Since then, WHO and UNFPA have monitored progress in MPDSR implementation. They noted substantial gaps between adopting national MPDSR policies, setting up national and subnational review committees and monitoring other aspects of implementation. Quality of reviews varies within and between countries. MPDSR methodology requires comprehensive investigation of causes, circumstances, and preventability of each maternal death identified and a no-blame atmosphere is essential to pinpoint and make policy and operational changes that would improve quality of care. UNFPA supports countries to develop MPDSR with tracking indicators that are clear and measurable, and methods for analyses that best assess quality of death reviews and can track the impact of death reviews on health service quality. Strengthening MPDSRs is supported by the MHTF as a vital mechanism to build sustainable systems strengthening for better MNH and is linked to the EmONC response.

Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive

Indicators:

- Alignment between global and regional **evidence-based guidance** and national strategies for establishing and operating a MPDSR process.
- Examples of **UNFPA advocacy and policy dialogue** in support of national plans designed to strengthen and scale up MPDSR.
- Strengthened **coordination and capacity** including increasing number of timely, complete death audits
- MHTF workplans include application of lessons learned (**knowledge management**) to improve quality and support scale-up of MPDSR within countries and to new countries.
- Number of **MPDSR components that are implemented** (out of four)
- Examples of investment by health authorities and partner institutions at global, national and sub-national level with a focus on the **relevance, effectiveness, and sustainability** of MPDSR process and relevant follow up.
- Health authorities and partner institutions regard MHTF **leadership on core principles** of equity in access, quality of care, accountability, and on principles related to human rights and gender equality as a critical underpinning of the MPDSR approach.

Observations	Sources of Evidence
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Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive	
<p>Implementation of MPDSR in Uganda</p> <ul style="list-style-type: none"> • In 2017, the MoH adopted the WHO Maternal and Perinatal Death Surveillance and Response (MPDSR) guidelines and rolled them to all the districts as a key tool for quality improvement and accountability in maternal and newborn health. 	MoH Uganda, The National Annual Maternal and Perinatal Death Surveillance and Response Report 2017/18, 2019
<ul style="list-style-type: none"> • The MoH introduced a safe motherhood campaign in 2002, which led to adaptation of the World Health Organization (WHO) guidelines on Maternal Death Reviews (MDR) in 2004. However, due to continuing high MMR, maternal deaths were declared a national emergency by the President in 2008 and all hospitals were required to routinely report and review all maternal and perinatal deaths that occur at their facilities to the national level. MPDR committees were established at both national and regional referral hospitals and were later cascaded to the General hospitals and Health Centre IVs. Standard reporting tools were developed and health workers in some districts and facilities were trained to conduct MPDR. The MoH and its partners supported confidential enquiry into maternal death. • In 2013, WHO provided guidance on Maternal Death Surveillance and Response (MDSR) to guide countries in their MPDSR processes. • The guidelines o 2017 are an adaptation of the WHO Maternal and Perinatal Death Surveillance and Response (MPDSR) guidelines. They are also based on lessons learnt over years as part of the Quality improvement processes for maternal and newborn health. • Several partners namely: UNFPA, WHO, UNICEF, USAID, URC-ASSIST, CDC World Bank, Save the Children in Uganda and, UNHCO have supported the MoH in implementing the MPDR process. 	MoH Uganda, Maternal and Perinatal Death Surveillance and Response Guidelines, 2017
<ul style="list-style-type: none"> • MPDSR is a quality improvement process. There is a need to work towards completing the whole cycle: the first big struggle is to have the appropriate tools in place. There are very good strategies and guidelines – and lots of discussion on how to train MPDSR to manage – but how do we ensure the right forms? • MPDSR is at the facility level still – the community level is not yet involved. There is a need to look at how to look at maternal deaths in the community and add that piece as well. Also, the response part, that is where the discussion happens, for example with the PPH framework and the revision of guidelines. There is currently a very big push towards reducing deaths due to PPH – but that is just one piece of the puzzle. The main question is how to make it happen – to improve the quality of maternal health services – the referrals from community to HCIII, and from HCIII to HCVI – how can we connect all these pieces together? There needs to be a systems approach – you need to increase the number of midwives, but if you do not have gloves, you might know how to use magnesium sulphate, but the drug is not available. The holistic approach for quality of care in MPDSR – that has to be emphasized. The blaming of the health worker is long gone – not so much an issue anymore – but now more looking at how to improve the system around it. 	Interview, Development partner, Kampala, May 2021
<p>UNFPA support for MPDSR</p> <ul style="list-style-type: none"> • National MPDSR committee meetings were revitalized through the conduct of quarterly meetings and regional confidential inquiries. At district and facility levels, UNFPA supported the MoH to conduct facility-based mentorships to build capacity of 	UNFPA Uganda, Final Annual Report for MHTF, 2020

Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive	
<p>health workers and facilities committees to conduct MPDSR, including the review of deaths and reporting into the HMIS. Maternal death notification increased from 59 to 76 per cent, and reviews increased from 51 to 66 per cent between 2019 and 2020, respectively. MHTF support to the MoH for these activities was complemented with funding from Sida, USAID and CHAI.</p> <ul style="list-style-type: none"> • UNFPA participated in joint weekly meetings with the MoH National MPDSR committee, which focused on MPDSR at National Hospitals (Kawempe and Mulago Women’s and Neonatal Specialized Hospitals). These meetings have served to spur action and strengthen response to maternal and perinatal deaths through confidential inquiries. In addition, in response to observed gaps, UNFPA mobilized funding from MTN-Uganda to support renovation and equipment for the Neonatal unit at Kawempe National Referral Hospital and a consultant Neonatologist to support its establishment and functionality. Between October and November 2020, the number of neonatal deaths declined from 111 to 67 deaths at the hospital. • “With the MTHF catalytic funds, UNFPA supported the MoH to strengthen the response aspects of the MPDSR in the following ways; (1) conduct weekly high level multi sectoral review meetings at the Kawempe National Referral Hospital (Referral hospital for Maternal Health), (2) support regular confidential inquiries in select regional Referral Hospitals which reported high referral rates and maternal deaths, (3) supported Kawempe National Referral Hospital (NRH) to support high volume lower lever facilities in the Kampala Metropolitan area, and (4) supported the functionalization of the Neonatal Intensive Care Unit (NICU) in Kawempe NRH through the hiring of a neonatologist, who built the capacity of the care teams. During this period there has been an observation of reduction of neonatal deaths at the facility.” (p.3) • “The National MPDSR report for FY2019/20 was Compiled and Validated by a team of national stakeholders in the National MPDSR committee and was also presented to the Maternal and Child health cluster which forwarded it to the MoH Senior Management for Adoption and Final endorsement by the Director General of health services.” (p.4) 	
<ul style="list-style-type: none"> • UNFPA supported MoH in the implementation of MPDSR cycle at national and sub-national levels with emphasis of strengthening maternal death notification, quality reviews and responsiveness to recommendations as part of the key indicators for improving service delivery in health facilities. • UNFPA supported the compilation and dissemination of the Annual MPDSR Report (September 2019) to ensure continued quality improvement. There was increased awareness among stakeholders on the use of MPDSR as a quality improvement tool for mitigating occurrence of maternal deaths. However, the functionality of MPDSR Committees at district and health facility level remained a key challenge and the main weaknesses were as follows: <ul style="list-style-type: none"> ○ Majority of facility MPDSR committees were not fully constituted and non-functional. ○ The MDPSR committees at both district and facility levels were not well oriented on the process of MPDSR, the formulation of the MPDSR committee, the roles of the members and the reporting mechanism to MoH. ○ The revised tools were not available at both district and facility levels. ○ Inadequate technical support supervision provided by some district MPDSR committees to health facilities; and this was because the district MPDSR committees were not functioning. • In order to improve the MPDSR system further, the following aspects need to be advocated by UNFPA in liaison with MoH: <ul style="list-style-type: none"> ○ Strengthen the MPDSR committees at district and facility level through orientation of the members about their roles and responsibilities on the committees 	<p>GoU and UNFPA, UNFPA 8th Country Programme, 2016-2020 Evaluation Report, 2020</p>

Assumption 3.1: MHTF technical support to the establishment and national scale-up of MPDSR in its partner countries is evidence based and comprehensive	
<ul style="list-style-type: none"> ○ Strengthen the community level intelligence/surveillance for maternal deaths ○ Encourage and monitor pregnancy mapping and tracking by VHTs and ○ Orient political/technical leaders on the importance of MPDSR and safe motherhood” (pp. 34-35) 	
<ul style="list-style-type: none"> ● UNFPA supported the MPDSR process by funding specialist team visits to lower-level facilities to understand the root causes of the high number of referrals and increase in maternal and perinatal deaths at Kawempe. UNFPA also supported the MoH in the implementation and follow-up on recommendations and action points. In 2020, the MoH senior management (including permanent secretary and directors of department) visited Kawempe to understand the drastic increase in maternal and perinatal deaths. As a result, the PS recommended to send technical teams to visit the referring facilities, help address the gaps and causes at this level, reduce the referrals, and therefore decongest Kawempe. UNFPA funded those team to visit the lower-level facilities in November and December 2020 and will soon fund follow-up visits through the MoH. As a result, there has been a 45 per cent reduction in the number of referrals coming to Kawempe from these health facilities. 	Interview, MoH service provider, Kampala, May 2021
<p>Government commitment for MPDSR</p> <ul style="list-style-type: none"> ● The MoH places a top level of priority on MPDSR, supported by the World Bank Uganda Reproductive, Maternal and Child Health Services Improvement Project (URMCHIP), UNFPA, USAID, WHO, UNICEF and CHAI among others. In 2020, with maternal deaths spiking, it renewed efforts to implement MPDSR as an important continuous quality improvement (CQI) tool in the provision of MNH services. “Using the revised National MPDSR guidelines, the focus for 2020 has been on increasing mandatory notification and reporting for all maternal and perinatal deaths, functioning of facility, district and national MPDSR committees, review of all deaths and response by implementing recommendations at the different levels.” (p.7) ● “Leadership on MPDSR has turned the tide on quality of care for Maternal health starting with National and Regional Referral Hospitals plus Urban Authorities. The leadership of the MoH top leadership and involvement of critical stakeholders for commodity supply, urban authorities, referral hospitals and donors; has greatly reduced unnecessary referrals along the referral pathway for maternal health. These regular (weekly) interactive meetings have also been platforms for resource mobilization, and efficient allocation. They have also been an accountability platform for resources allocated as well as collective problem solving.” (p.19) 	UNFPA Uganda, Final Annual Report for MHTF, 2020
<p>UNFPA support to for follow-up of MPDSR action points/recommendations</p> <ul style="list-style-type: none"> ● UNFPA supported root cause identification at regional referral hospitals (RRH): UNFPA <u>Sida</u> funds the specialist teams to visit lower level referring hospitals to discuss and identify the root causes (i.e. those facilities referring to Kawempe and Mulago). ● Support for a new neonatal unit at Kawempe: UNFPA provided equipment and materials for the new neonatal unit at Kawempe funded a neonatologist to come up with protocols of care, train and mentor the teams through the diff drills of care for emergency conditions for the neonates, how to use the new equipment in the neonate intensive care unit etc. <p>Results:</p> <ul style="list-style-type: none"> ● “Unnecessary” referrals to Kawempe almost dropped to zero – e.g. the blood supply to the regional referral hospitals (RRH) improved (through strengthened blood supply chain) and blood transfusions are now handled at that level, and no longer referred to Kawempe. 	Interview, UNFPA Uganda national staff, May 2021

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<ul style="list-style-type: none"> • Kawempe has been decongested through reduction of referrals, but also by referring women who need C-section from Kawempe to other hospitals, if the theatre at Kawempe is full (i.e. strengthened referral system between National Referral Hospital and Regional Referral Hospitals) 	
<ul style="list-style-type: none"> • MHTF funds and advocacy for the compilation of the annual MPDSR report has been catalytic since it gained the interest and support of the MoH, attracted other donors/partners, and Sida-funded UNFPA to operationalise MPDSR at the district level. UNFPA has played an instrumental role, alongside WHO, in advocating for the MPDSR process and making the evidence about the root causes of maternal and neonatal deaths available. MoH gained interest and picked it up, and the MPDSR is now spearheaded by the senior management of the MoH. UNICEF and USAID came on board with technical and financial support later on (although it is not clear exactly what year). Moreover, Sida has come on board and started funding UNFPA to strengthen district MPDSR committees. • As a result of the weekly MPDSR meetings (supported by UNFPA and other donors), a national Postpartum Haemorrhage (PPH) Action Framework was developed to address the weak blood supply chain system, causing women to die from PPH. As part of this, UNFPA supports research and revision of the list of life-saving drugs, i.e. shifting from oxytocin (which requires a cold chain) as first line drug to other heat stable drugs. • “We started developing national MPDSR reports in 2015; the first was published around 2016. Since then, we have seen that PPH is the major cause – it is globally like that – but for us it is consistently high. The MPDRST reviews are only about 66 per cent (2020) – so only 66 per cent of reported death (not notified) were reviewed.” • UNFPA/MHTF has contributed the MPDSR alongside WHO. At recent time, MHTF has supported that MPDSR reports come out on a regular annual basis – what the main issues are – tasking the MoH to commit, to support some of these areas that have been identified as weak – the MPDSR annual report is bringing out some of those gaps. “This year, we need to have a deliberate PPH framework – to address the PPH root causes – The reports were demonstrating that this was the key issue – and it informed the decision to develop a PPH framework.” • Regularly, every year, MHTF has funded the compilation of data, analysis etc. of the annual report. UNFPA also funds the districts to conduct regular MPDSR at the district and facility level, so that has improved the functionality of these committees. • For the first report, WHO and UNFPA both provided funding to compile data from the last 3 years. UNFPA funded the dissemination of the report, including at district level. It is now a country-led process to establish the MPDSR report. Last year, MHTF funded the MPDSR annual report – USAID funded further dissemination of results – so lower level RHH and HC III ad VI can take action, develop action plans. WHO has also added resources. UNFPA has contributed to the compilation of the report. In 2018, it was only UNFPA who supported a very comprehensive compilation and analysis. The others provided technical input, but not funding. In 2019, we picked interest from other partners who supported, they got interested, and the dissemination was expanded. UNICEF, they also contribute, especially the perinatal aspect. • “After the very first report 2016, there was “laxity” – not very much interest for this report. MHTF then started supported the annual reports – every year very consistently. UNFPA and WHO advocated very strongly for the MPDSR report in the beginning, other donors did not see the importance, even the MoH was not that much interested. It was pushed by UNFPA and WHO.” 	<p>Interview, UNFPA Uganda staff, Kampala, May 2021</p>

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<ul style="list-style-type: none"> • UNFPA mainly supports the compilation, not the dissemination. • “When the first reports came out, MoH realised what the gaps where, and there was a need to take action. Also, with the deaths happening, we started improving surveillance – how many deaths have happened where. So, they started picking interest. Also, the president of the country is supporting MPDRAT, he instructed the MoH to investigate and document every maternal death. He usually asks what the responsibility is for those mothers who died. That political will and support increased the interest and demand for the MPDSR report.” • Previously, the analysis happened ad hoc – parliament asked to investigate a case of maternal deaths. But now it is a structured process. 	
<p>MoH perspectives on UNFPA support</p> <ul style="list-style-type: none"> • MPDSR is a quality improvement approach and meant to work as an entry point to identify the critical gaps and issues that lead to maternal deaths. “With UNFPA support we are able to analyse the data every week, take action every week, and follow-up on the actions. Initially, we were at a quarterly level for MPDSR meetings, but now they are weekly.” • It would be helpful to support districts with data or IT equipment, so that the DHOs can participate in those meetings (ADHO) via Zoom – they need data etc. “We are trying to use technology to ensure that there is a close exchange of ideas, also for the good practices. Even DHO peer learning and peer support can help – and that is where we need UNFPA and others support.” 	Interview, MoH official, Kampala, May 2021
<ul style="list-style-type: none"> • UNFPA does not have resources to support MPDSR in a country of 130-140 districts. MHTF only supports the compilation of the national report last year, but UNFPA had Sida funds to support MPDSR district capacity building in 14 districts. Sida also funded Kawempe and Mulago MPDSR. • “UNICEF also can fund MPDSR in other districts. In regions where we “converge”, i.e. UNICEF and UNFPA in West Nile – we have created quarterly coordination meetings WHO-UNICEF-UNFPA – specifically for West Nile and Acholi region. They are both there, but they are doing <i>similar</i> things – not the same. The coordination meeting is to ensure that there is no duplication or overlap – but expansion of coverage - ensuring maximum coverage. Both UNICEF ad UNFPA have IPs there, and we meet to make sure that their support is well coordinated. I have asked UNFPA and UNICEF to ensure that their regional offices also make similar coordination meetings. It was one of UNFPA conclusions of last year – that we needed to have those regional strong platforms UNICEF-UNFPA-WHO. Not sure if it has yet been operationalised.” 	Interview, UNFPA Uganda national staff, Kampala, May 2021

Assumption 3.2: MHTF support has addressed the need for sustained or increased quality or credibility of maternal and perinatal death audit as evidenced by increased notification of maternal, perinatal and neonatal deaths in national and sub-national systems and increased implementation of responses
<p>Indicators:</p> <ul style="list-style-type: none"> • Quantifiable increase in the notification of deaths to health facilities, districts and other authorities • In target areas, increasing or continuing number and frequency of MPDSR events and hearings with multi-stakeholder participation • Examples of policies and processes to support improved quality and comprehensiveness of death audits at national and at sub-national levels • Examples of UNFPA efforts to strengthen QI processes, tools and data collection at national and sub-national level linked to MPDSR

<p>Assumption 3.2: MHTF support has addressed the need for sustained or increased quality or credibility of maternal and perinatal death audit as evidenced by increased notification of maternal, perinatal and neonatal deaths in national and sub-national systems and increased implementation of responses</p>	
<ul style="list-style-type: none"> National and sub-national health and district supervisory officers in areas supported by UNFPA implement MPDSR monitoring on a regular basis and utilize findings to support improvements in services Views of health officials, including facility managers, providers and community members regarding credibility of MPDSR processes. 	
<p>Observations</p>	<p>Sources of Evidence</p>
<p>Reported progress/challenges in 2018 During FY 2018/19, the MoH conducted the following MPDSR activities as part of the national response:</p> <ul style="list-style-type: none"> Provided MPDSR feedback and mentorship at the beginning of FY18/19. Held Parliamentary meetings with the Parliamentary Committee on Health. Conducted data spot checks. Revised MPDSR Tools to align with the requirements in HMIS. Provided monthly updates in the MCH Technical Working group. Strengthened the perinatal component; with support from UNICEF, conducted a national PDSR Training of Trainers aimed at improving regular reviews of perinatal deaths. Sixty-five (65) TOTs were trained. The report noted that, in general, technical support supervision provided by district MPDSR committees to health facilities was inadequate. Reasons for this included: <ul style="list-style-type: none"> Some districts do not perceive MPDSR as a priority except when there are partner-funded, focused programmes Limited integration of MPDSR in workplans Inadequate involvement of district leadership DHTs not sharing reports with political leaders MPDSR is led by nurses/midwives and not doctors Lack of feedback to/from referring facilities Inadequate support from supervising referral hospitals Multiple avoidable factors led to maternal deaths, i.e., low numbers of health service providers at delivery points; low skills in EmONC; poor referral mechanisms; fear among health workers to handle high risk mother; lack of fuel for ambulance(s); and lack of blood and blood products. It was observed that some health facilities fear to report maternal/perinatal deaths as they fear reprimand from district leaders, politicians and/or the police. Sometimes, next of kin are told to take away the deceased without any record of having attended the health facility. Cases of perinatal death are misreported as abortions or as a child death. Some of the approaches used include conducting monthly reviews of maternal deaths by in-charges and DHOs, follow-up phone calls to sites with maternal deaths; reporting via personal mobile phones using WhatsApp; streamlining the review process, etc. 	<p>MoH Uganda, The National Annual Maternal and Perinatal Death Surveillance and Response Report 2017/1, 2019</p>

Assumption 3.2: MHTF support has addressed the need for sustained or increased quality or credibility of maternal and perinatal death audit as evidenced by increased notification of maternal, perinatal and neonatal deaths in national and sub-national systems and increased implementation of responses	
<ul style="list-style-type: none"> • Regional efforts to address these gaps included on-site mentorship of CEmONC facility teams, implementation of quality improvement projects aimed at reducing facility delays accessing emergency obstetric care. USAID supported procurement of MNCH equipment such as BP machines, resuscitation equipment, thermometers and delivery kits to USAID/RHITES supported districts. • In 2017/18, over 1,100 maternal deaths were recorded in the HMIS. Of these approximately one-half (49 per cent) were notified and 47.5 per cent were reviewed. This represents an increase from 2016/17 in which 27 per cent were notified and 27 per cent were reviewed. This improvement is attributed to training of providers in MPDSR. • A total of 131 out of the 134 (97.8 per cent) districts in the country are notifying maternal and perinatal deaths through the DHIS-2. However, out of the total number of districts that notified maternal deaths, only 76 (58 per cent) carried out reviews. Introduction of results-based financing (RBF) through the World Bank may be used as an innovation to support committee functionality. • Maternal death notification increased from 50 per cent in FY 2017/18 to 58.5 per cent in FY 2018/19. (National HSDP target = 85 per cent.) The increase is attributed to revitalization and formation of MPDSR committees, training of health workers and HMIS records officers on MPDSR reporting and data management and increased awareness on use of MPDSR as a quality improvement tool for mitigating occurrence of maternal death among stakeholders. • There was an increase in perinatal death reviews from 8 per cent in Q1 to 34 per cent in Q4. 	
<ul style="list-style-type: none"> • In 2018, UNFPA reported “slight improvement” in functionality of MPDSR system at national, district and facility levels. Several reasons are cited to explain the low proportion of deaths that are reviewed including, poor records management especially at lower facility levels, mixing of death files with others making it difficult to retrieve the files, stock out of MPDR tools, lack of critical staff with capacity to analyse causes of death and lack incentives for MPDSR committees hence non-functional committees at facility level. Others include non-functional response system which demoralizes the committees as the process is seen as a waste of time. All these areas have been identified to improve action for result based programming. Collection, analysis and writing of the annual MPDSR report is in progress. UNFPA continues to support compilation and reporting of annual MPDSR reports at both district and national levels to ensure continued quality improvement. 	UNFPA Uganda. 2018 MHTF Annual Report. 2018.
<p>Recommendations identified 2018</p> <ul style="list-style-type: none"> • Hold regular national, regional and district MPDSR committee meetings and on-site support • Roll out newborn register and perinatal death notification form • Functionalize newborn care units at HCIV facilities and hospitals with special allocation of staff to neonatal units including a medical officer at district and RRH. 	MoH Uganda, The National Annual Maternal and Perinatal Death Surveillance and Response Report FY 2018/2019, 2019
<p>Reported progress/challenges in 2019</p> <ul style="list-style-type: none"> • In Q3, UNFPA supported a select team of the MoH National MPDSR committee to analyse and draft the Annual MPDSR report through a process of collection, compilation and entry of data on Maternal and Perinatal death reviews into the e-HMIS. The Final Draft report was submitted to the National Committee for Validation and Presentation to the MCH cluster 	UNFPA Uganda, GoU/UNFPA Country Program Support to MoH 2019 Annual Workplan, 2019

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<p>and Senior Management Team for adoption in October 2019. Concept notes were written for the development of an electronic tool to track MPDSR implementation at Sub-national level and for the Development of the Costed National Implementation Plan; both are awaiting approval and availability of funding from UNFPA.</p> <ul style="list-style-type: none"> In Q4, the Draft Monitoring Tool for Tracking Implementation of MPDSR at National and Sub-national level was developed, with plans for pre-testing in 2020. MoH developed a Draft National Implementation Plan for MPDSR which will be costed in 2020. 	
<ul style="list-style-type: none"> Efforts in FY 2018/19 to improve the MPDSR processes via continuous training and mentorships resulted in increased notification and reviews. The introduction of Results-based financing (RBF) helped to incentivize the functionality of the committee and implementation of MPDSR recommendations. “However, gaps remain in the quality of recommendations, follow up and implementation at all levels. The national MPDSR committee needs to innovate a strategy that will enable committees at all levels to carry out their roles.” (p.11) <p>Progress made in 2018/19:</p> <ul style="list-style-type: none"> At the national level, quarterly MPDSR committee meetings to share experiences from select facilities, districts and regional levels. The following activities were implemented to improve timeliness and quality of MPDSR reports: “a. Training of frontline health workers on documentation and timely reporting. b. Printing, distribution and orientation on the revised MPDSR tools including the new perinatal death notification form and the newborn register were accomplished. c. On-site and virtual mentorship on MPDSR data management process including entry into DHIS2. d. Conducted targeted data quality assessment (DQAs).” (p. 12) Newborn care units at HC IV and hospitals was improved through a special allocation of staff to neonatal units including a medical officer at district and RRH. Guidelines for the care of small and sick new-borns were finalized and adopted to support capacity of staff to correctly diagnose, treat and document new-born conditions Access and availability of blood products, supplies and consumables was improved through equipping, training and onsite supervision of all CEmONC facilities in collaboration with the regional blood banks. <p>Selected results:</p> <ul style="list-style-type: none"> A total of 1,182 maternal deaths were reported (HMIS 105). Of these, 923 (78%) were reported through MTrack weekly surveillance report but only 496 (42%) were notified within 24hrs and captured on DHIS2. A total of 779 (66%) maternal deaths reviews were entered into the DHIS2 Event Report (FY 2019/2020). A total of 28,050 perinatal deaths were reported (HMIS 105). of these, 38% (10,741) deaths were reported through MTrack weekly surveillance report and 10% (2,744) were reviewed and entered in the DHIS2 Event Report (FY 2019/2020). (p.14) IMMR (Institutional Maternal Mortality Rate) has stagnated over the last five years with a small dip in FP 2018/19; however, the dip was not sustained in FP2019/20, likely due to COVID-19 lockdown restrictions. 	<p>MoH Uganda, The National Annual Maternal and Perinatal Death Surveillance and Response Report FY 2019/2020, 2020</p>

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<ul style="list-style-type: none"> • The majority of maternal deaths occur in general hospitals followed closely by regional referral hospitals. “This implies that the MNH Quality of Care at RRH and general hospitals needs to be improved. Also, the efficiency of the referral system needs improvement in terms of timeliness; availability of logistics, such as ambulances and their readiness to transport mothers; inter-facility communication; and pre-referral management.” (p.47) • “Maternal death notifications and reviews improved over the past five years, with the greatest improvement between FY 2018/19 and FY 2019/20. This was attributed to the decentralization of entry of maternal death notifications and review reports at facility and district level as opposed to the entries being made centrally at MoH previously.” (p.47) “However, committee functionality remains a key challenge in some districts and facilities. This will remain a focus area in the next financial year to improve on death notification, reviews and actioning of proposed recommendations.” (p.49) • PPH contributed to 39 per cent of maternal deaths over past two years, closely followed by hypertension. • Only 28 per cent of maternal deaths who had labour were monitored with a partograph. This was attributed to HR gaps. • Of the first two delays, delay to seek care was the most avoidable factor contributing to maternal deaths. Reasons given include inadequate information of birth preparedness, lack of partner support, lack of transport, especially for the 10-19 age group. • Inadequate staff is the reason for delay at the third delay, especially at HCIII and HCIV level facilities. Shortage of essential MNH medicines and commodities “is rampant across all levels of health facilities.” (p.48) • Institutional Perinatal Mortality Rate (IPMR) decreased over the past five years, from 30 per 1000 births (2014/2015) to 23 per 1000 births (2019/2020). The decreasing trend can be attributed to increased efforts by the government and partners to establish new-born care units. Interventions have been implemented, such as: Neonatal resuscitation (HBB), essential newborn care, care of the small and sick newborn (kangaroo mother care, use of oxygen, nasogastric tube feeding with breast milk, use of antibiotics and phototherapy). However, the macerated stillbirth and fresh stillbirth rates have stagnated between FY 2018/2019 and FY 2019/2020 at 9 per 1000 births. This can be attributed to gaps in the quality of care offered during ANC, labour and delivery. Majority of the fresh stillbirths occurred at National Referral Hospital (23 per 1000 births) and RRHs (20 per 1000 births). “This is further explained by delays in performing of caesarean section, 63% of the fresh stillbirths were performed greater than 30 minutes at the CEmONC facilities. This could be explained by the high volume of deliveries and among the avoidable factors, absence of critical Human resource was commonly observed. The National Referral Hospital is also overburdened which explains the delay and lack of consumables. It is crucial to functionalize the lower health units to decongest the National Referral Hospital.” (p.50) 	
<p>Findings from 2020 MPDSR reviews:</p> <ul style="list-style-type: none"> • Inadequate supply of uterotonic drugs (Pitocin), MgSO₄ at the district hospitals, and lower units (can be avoided by increasing stocks during the quantification process as orders are compiled). • Poor referral systems due to lack of means of transport and some districts lack ambulances to transport emergencies. 	<p>MoH Uganda. The National Annual Maternal and Perinatal Death Surveillance and Response (MPDSR). 2020.</p>

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<ul style="list-style-type: none"> • Delay to decide by the patient and the family to go to a nearby facility for safe deliveries, some mothers go to traditional birth attendants where they are delayed and are brought in poor condition, others delay at home due to cultural beliefs, knowledge gap, poor male involvement, etc. • Knowledge gap on obstetrical emergencies among health workers and do not follow provided protocols and SOPs, e.g., partographs filled out after delivery, labour monitoring was informal. • A range of challenges to implement recommendations at facility level were noted. Among them are: stockouts of essential medicines, insufficient HMIS tools, high turnover of staff, limited funding, poor provider attitudes (no incentives), lack of power/no generators at CEmONC and BEmONC facilities, knowledge and skills gaps, internet connectivity, etc. 	
<ul style="list-style-type: none"> • A meeting was held between the MoH and Kawempe National Referral Hospital in September 2020 to review MPDSR. Two maternal deaths were reviewed and highlighted “missed opportunities” such as delays in conducting labs, lack of critical drugs, delay in decision-making for delivering the patient, challenges in the transfer of mothers to other levels of care, lack of multidisciplinary care, no functional monitors and oxygen, lack of human resources in the theatre room. The MPDSR team recommended use of RBF money to fill the gap in patient care. 	Lukakamwa, D, Minutes from meeting held between MoH Uganda and Kawempe National Hospital, September 2020, 2020.
<p>General summary recommendations made from the maternal and perinatal death reviews at facilities:</p> <ul style="list-style-type: none"> • Strengthen health provider skills and knowledge through training, mentorship, CMEs, and supportive supervision to address addressing knowledge gaps in areas of EmONC and HBB. • Improve on number of staffing (doctors & midwives) through recruiting critical cadre staff, set up a neonatal resuscitation team, etc. • Equip health facilities with equipment such as monitors, better operation tables, provision of adequate lighting in the theatre • Ensure a constant blood supply and other products like fresh frozen plasma and platelets. • Improve the supply of EmONC drugs and supplies. • Encourage mothers to attend ANC for early identification of risky conditions. • Improve documentation • The report identified best practices in MPDSR implementation by highlighting a case where the MPDSR cycle was completed. This included conducting death reviews at facilities from where the mother was delayed. This requires a committed team of health workers who emphasize the principle of (no name, no blame) so that the health workers can tell the truth and hence develop actionable recommendations at the end. It is important to give positive feedback to the referring facilities together with the district officials to improve systems and care. 	MoH Uganda, The National Annual Maternal and Perinatal Death Surveillance and Response (MPDSR), 2020
<p>UNFPA inputs to follow-up MPDSR findings</p> <ul style="list-style-type: none"> • “UNFPA also supported Kawempe NRH and Kampala Capital City Authority (KCCA) to identify facilities that were the hotspots for maternal and perinatal deaths in the Kampala metropolitan area. Kawempe NRH offered technical support to all these facilities in identifying quality care gaps and addressing them. The aim of this support is to reduce on unnecessary referrals as well as maternal and perinatal deaths. Joint technical visits to other referral hospitals (Mulago Women’s hospital and 	UNFPA Uganda, Final Annual Report for MHTF, 2020

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<p>China Uganda Hospital-Naguru) in the city have decongested Kawempe NRH by strengthening collaboration and joint responses for CEmONC services. (p.7)</p> <ul style="list-style-type: none"> UNFPA supported the MoH National MPDSR committee to compile the Annual MPDSR report 2019/20. Key Analysis and Observation of the report have been incorporated into the national health sector performance report 2020 and validated by the maternal and child health cluster.” (p.7) Maternal death notification increased from 59 to 76 per cent between 2019 and 2020. Reviews increased from 51 to 66 per cent in the same period. CHAI and USAID supported the MoH to carry out facility-based mentorships to build capacity of health workers and facility committees on MPDSR, including reviewing deaths and supporting data input to HMIS. 	
<p>Improved processes lead to increased motivation and problem-solving</p> <ul style="list-style-type: none"> There is a weekly platform (weekly MPDSR and PPH platform) where deaths are identified at national level. It is chaired by the Assistant Commissioner for Reproductive and Infant (R&I) Health and includes champions from academia, IPs, RRH representatives. When the deaths are reviewed, the group tries to find the common issues, and then works with partners to reach out to the facilities. This motivates the referral sites and health workers – they know that the reviews/reports will be looked at and action taken – and support given to solve the issues, so that motivates them to continue the reviews. These meetings started March this year. UNFPA plays a role in the meeting by providing technical input. UNFPA provided technical support and funded the costing of the PPH national framework. UNFPA also support the extension to the Regional Referral Hospitals (RRH) – to functionalise their regional MPDSRT committees (Hoima region and West Nile). With funding from Sida, UNFPA supports capacity building in a number of districts on MPDSR, especially to support quality reviews, notification, reporting. UNFPA also supported KAWEMPE national hospital and the Mulago Women and Neonatal specialised clinic to improve their MPDSR process – and the quality improvements in terms of quality of care. “We have also supported them to provide axillary support to the referring facilities around Kampala. We have supported Mulago and Kawempe to go and do mentorship and build the capacity at their level – for the reasons for which they have been referred – we mapped the facilities that refer to Kawempe and Mulago – and the reasons for referrals – UNFPA supported the national teams to go and do problem-based quality improvement and support through mentorship.” The objective was to have those facilities have enough capacity to deal with their issue themselves. There were many fresh stillbirths at Kawempe, because they were overloaded, and referred. “We felt that many of the cases should be handled at that lower level (CEmONC sites – and some selected BEmONC) - they focused on the General Hospitals and HCVI (but added some few HCIII). That was UNFPA funding – the national teams going to those referring hospitals to fill the skills gap – the main funding was Sida and MHTF – though we continue to incorporate other aspects.” 	<p>Interview, UNFPA Uganda national staff, May 2021</p>
<p>Challenges in implementation of MPDSR</p>	<p>Interview, UNFPA Uganda national staff, May 2021</p>

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<ul style="list-style-type: none"> • While the MPDSR policy and structures are very clear, the challenge is the implementation of the policy and action points. The main issue is the non-response to the “national action recommendations” – from the lower levels. Action points coming from facility level reviews are often not implemented – and that demotivates the facility to do the reviews. If the district level MPDSR is not able to respond to the recommendations/action points – supporting the facilities to rectify the issues (solve the problems) – if the district committee is not functional and not supportive of the facilities – the facilities will lose interest. Sometimes the district does not have the funding. The motivation dies when there is no action. • “At national level, referrals and the blood have been huge issues. We have now tried to work on a referral system, so there are more systematic referrals. It is under conceptualisation – we have created an emergency medicines department – and one of the objectives is how to improve emergency services (and referrals) including the maternal/neonatal emergencies.” • In the beginning, there was more “punitive action” – blaming the health facilities, so health workers withdrew. “Since then, we have emphasised the “no blame game”, that the objective is learning. There is a lot of attitude change at facility level regarding these reviews. In 2016-2017, they would not review, not report, of cause of fear. They would not report the deaths. Making the whole thing being on the head on the health workers, discouraged them. It is changing now, although we still have cases of where they are hesitant to report death and review, but there has generally been a positive change over time. Also, whenever we publish the reports, IPs and other support the process. The National level also does “confidential inquiries” – they are not just information picking – but also to support capacity building.” 	
<p>District/service delivery perspectives on MPDSR</p> <ul style="list-style-type: none"> • Marie Stopes Uganda (MSU) aims to build capacity of DHO and health facility staff to strengthen MPDSR structures and processes; however, this is in the initial stages. There are initial challenges with following up on actions/recommendations from the MPDSR review meetings due to lack of funding/transportation to involve lower level referring facilities where the delays/issues often start. To overcome this challenge, MSU is providing support to facilitate their participation/transportation. The interviewee noted that the action points seem to be followed up, mainly through mainly through mentorship and supervision. 	<p>Interview, NGO national partner staff, Arua District, Uganda, May 2021</p>
<ul style="list-style-type: none"> • MPDSR started in the district around 2015/2016, when first MoH guideline was received. MPDSR is a quality improvement intervention under MoH, with a policy guideline to support it. Districts are mandated to conduct MPDSR. However, health practitioners have been slow to embrace it. Partners have identified it as a strategy that can be a game changer in addressing maternal health, therefore they are supporting districts to strengthen that system. • “Marie Stopes has provided us with some support. But they are not the first, AVSI had already started supporting us in this area before. We also had a USAID-partner, ASSIST, in 2014-2015. Even RHITES North-Acholi also supported us in MPDSR, starting in 2017-2018, but they are not really active in maternal health.” • At the moment, Marie Stopes supports the facility-based review meetings. The most important step in MPDSR is the problem identification – or identify that intervention (good practice) to prevent a death. So, Marie Stopes works with the DHO to identify “resource persons” with good skills – and Marie Stope supports that “resource person”– to become mentors for the MPDSR – and go support reviews at facilities. 	<p>Interview, MoH staff, Lawmo District, Uganda, May 2021</p>

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- In 2018, a team of four staff from DHO (including the ADHO, but not the DHO) received a 5-day training of trainers (ToT) on MPDSR – took place in Gulu – it was conducted by MoH with support from USAID.
- At the moment, Marie Stopes is not doing any ToT, and they just started. In time, a refresher training is needed for existing trainers and to add new trainers for MPDSR. Lawmo is a large district, and the 4 DHO staff trained on MPDSR is not enough, they cannot cover the entire district, especially since MPDSR is not their only responsibility. If every HC III or HC VI had one trained person in MPDSR – to support others, it would be very good.
- MPDSR is still in its infant stages in our districts.
- Death notifications have increased over time. But to ensure sustained increase, **more training/capacity building is needed** to consolidate and sustain efforts. Guidelines and tools have helped.
- The **timeliness of the committees at the facilities to sit and audit an occurrence still needs improvement**. When an instance occurs, the committee sits, but not always within 24 hours. Sometimes they delay and sit only within 48 or 72 hours – but it would be good to sit immediately – even if not everyone can be there right away – because it is an opportunity for you to learn, take action, and do something differently.
- “When MoH introduced MPDSR into the system, in the beginning, the way it was brought and being enforced by the MoH, it appeared as if it was a **“fault finding intervention.”** So somehow, many health workers retracted. You can imagine, at that point, if a mother died, the committee sat down, identified that the doctor who should have done operation, was not available, therefore the recommendation is “doctor should be more available” – report would be sent to MoH, with a monitoring done by the president’s office – they would follow-up on the case and arrest and prosecute the doctor. So, it appeared to be a punitive intervention. When the MoH realised that they started changing the approach. That made it difficult for health facilities to immediately report, because you would be considering, if I report, how safe will I be? HCW did not feel safe of the consequences when they reported. But it is changing, because all of us realise that moving in that direction will not help. During that time, reporting was so low, HCW would keep quiet. So moving forward, we need to show HCW that when they report, we support them in removing the challenges, not punishing them. We identify the challenges, e.g. if the commodity (e.g. misoprostol etc.) was lacking, and that was the reason for the bleeding/death, then we should help solve that problem. If the team reports that there was a challenge in the community, e.g. the first delay contributed to the fresh stillbirth, when this is brought to our attention, at DHO level, we should support the facilities to go to the community to talk with them. I think if we, DHO, show our facilities/providers that we are there to support them, they will be more comfortable supporting. When we have seen an increase in notifications and reviews, it is because **we DHO look at it that way – as a supportive intervention, not punitive**. In some places, there is an issue, and we need to take disciplinary action – or we place a senior person to support someone with skills lack.”
- **Timeliness of the review – and the reporting of the cases to the DHO – can be improved** if they feel confident and comfortable that “if I report, I will get support, not punishment”. That should be very clear in all messages to the health workers. “Learning is a continuous process, and sometimes you learn in the hard way.”

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<ul style="list-style-type: none"> The interviewee attended a district-level one-day orientation to MPDSR in 2018. Reviews are conducted when deaths occur by a committee; there are no regular meetings. The in-charge does not always participate. When a death occurs, the MCH use the notification form to review the case and submit it for the record. ☒ 	<p>MoH staff, Lawmo District, Uganda, May 2021</p>
<ul style="list-style-type: none"> In Gulu district, UNFPA supported the MPDSR process by training DHT and Health Unit Management Committees (HUMC) at the facility level and supporting MPDSR processes in three selected health facilities. UNFPA used MoH national and regional MDPSR trainers for those trainings. UNFPA support to training in MPDSR reviews has improved on auditing and giving the notification form from facilities to the district. The DHO team goes to work with the facility teams to identify the root cause of the death. However, the main challenge is having funds for inviting the staff from the lower-level facilities (who referred the woman to a higher-level facility) to participate in the MPDSR meetings, or from the health teams to travel to these lower-level facilities. Same issue seen in one of the facilities visited in Lamwo district. Also, the DHO stated that notification of community deaths is still a major challenge. UNFPA trained the DHT team. As DHTs, we then go to provide mentorship and support sites/facilities. UNFPA did not conduct the Training of Regional Trainers/Mentors, that is the national MoH trainers (funded by UNFPA), but they (UNFPA) come to supervise the ToT training at the district level. UNFPA also supported the DHO quarterly review meetings (general, covering the entire annual work plan of the DHO, including MPDRST, HIV etc.) Even before that, there was a training for the Health Unit Management Committees – trained by us, the DHO. UNFPA joins for the quarterly review meetings at district level, and also for the maternal death reviews in the three facility sites – or when they do supportive supervision, to see what we do in the MPDSRT Review Meeting. There was also a representative from MoH – Sister Agnes – to assist with the last death review meeting in St. Maurice Hospital (Gulu town). To ensure a quality MPDSR process, the DHO sits with the health care providers and HUMC members to look at the partographs and the registers – to see the quality of what has been documented. Problems are identified jointly with the facility staff, and reviews are conducted of what essential medicines were used, how was it administered, at what time was it done, the community representative was always there. The notification is still minimum – a lot of community deaths occur without notification. If a hospital has 12 deliveries in one night, there is a death, but it can take up to seven days before the death is audited – because the committees need to sit and verify. If it takes seven days to sit down and discuss, it will come late to our district office, but it has to be done within seven days. The process is as follows: <ul style="list-style-type: none"> Internal audit/review at the facility Notification of death to the district should happen within seven days (they do not notify immediately – only every seven days) Then the DHT goes and review together with the facility – we go to tease out what has been done right, what has not been done right. “We ALWAYS go – even without resources. But ad, there should be refreshments etc. especially for the community representatives.” 	<p>MoH, Gulu District, Uganda, May 2021</p>

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<ul style="list-style-type: none"> ○ Facility staff, DHT staff, community representative – the HUMC (internal). The DHT picks the people to go and review. There are a lot of referrals in – as stated early on, Gulu is picking patients from other districts who are already in a critical stage. ● Results-Based Financing (RBF) has really helped with supporting quality services – because RBF incentives are improving provider motivation and performance. The indicators are better after receiving the RBF payment. RBF is coming to the second year now – it goes to HC II and VI – not yet the hospitals. ● UNFPA also provides funds to train Health Unit Management Committees (HUMC). “We received the last financial report in March, waiting for our next disbursement – still waiting for the accountability. We had a lot of deaths which were not reviewed (during the lockdown period), identified by the MoH. In Gulu, we have a referral hospital, getting referrals from many surrounding districts/regions (Acholi, West Nile, Lango, part of Kiriadongo) – so we have (had?) many deaths. We started receiving support from UNFPA late 2020, we started implementing early this year.” ● But other partners are doing the same (MPDSR) – UNICEF is doing a similar activity in MPDSR but covering the entire district, HC III and VI - is open for all facilities in the district. UNFPA focuses only on 3 sites (i.e. health facilities) – UNICEF covers the other health facilities. UNICEF started supporting MPDSR this year. Before, they were more focused on HIV, but when the DHO raised the issue of high number of maternal deaths, UNICEF listened. “We said to UNICEF, can we please do more on dialogue/sensitisation of the communities on the importance on facility deliveries – using the HIV and TB funding.” ● “We need more UNFPA support for MPDRS – they only support 3 facilities (2 in town, 1 in the district) – we need funds for DSA to travel there for the day. If a death occurs at one of these three facilities, we sometimes need to go to the lower facility that referred the patient – but we do not have the funds to do so.” ● WHO also supports supportive supervision and surveillance – there is a WHO team based here in Gulu – they participate in maternal death reviews. “Surveillance was limping during COVID-19, WHO came to strengthen us.” 	
<ul style="list-style-type: none"> ● UNFPA provides support to DHOs to conduct MPDSR meetings. “We request that the DHO also report to us any incident that happens. They hold immediate review meetings – and they generate action points. And they have to follow- up on those action points. For example, they have to go to the community or facility to follow-up. So, we support the follow-up on those action points. We use the ADHO and the two district trainers/mentors – we facilitate their transportation/DSA etc. to do the follow-up.” The main challenges are with the follow-up of the action plans, as they DHOs often lack support. UNFPA “facilitates” (i.e., funds) some follow-up such as transport and DSA. Staff at lower levels need to be empowered to implement action plans. DHO has a budget for follow-up visits through Primary Health Care Grants, but it is inadequate. They must work within government structures and the limitations of government budgets. 	Interview, UNFPA Uganda national staff, May 2021
<p>Operations research on management of PPH</p> <ul style="list-style-type: none"> ● UNFPA is supporting operational research in collaboration with WHO on PPH management in West Nile and South Sudan. This is part of an effort by a coalition in East Africa to end maternal deaths due to PPH through the study of heat stable Cabetocin (prevention) and Tranexamic Acid (treatment of women with PPH). (Oxytocin is generally used, but there are challenges with the cold chain.) UNFPA staff are part of the technical meetings; other agencies have also provided TA. These 	Interview, MoH staff. Kampala, Uganda, May 2021

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drugs were recently approved by Health Policy Advisor Committee, which is chaired by the Permanent Secretary. “We are glad to have the TA from UNFPA.”

Area of Investigation 4: Obstetric fistula and other obstetric morbidities

Evaluation Question 4: To what extent has the MHTF contributed to the capacity of governments to develop, implement and monitor costed and time-bound national strategies for ending fistula cases that are founded on: prevention; access to quality treatment of fistula cases and other obstetric morbidities; and social reintegration of obstetric fistula survivors?

Sub-questions:

- a) To what extent has MHTF/ UNFPA contributed to the government capacity to develop, implement and monitor costed and time-bound national strategies for ending fistula?
- b) To what extent has MHTF/UNFPA contributed to building government capacity at national and sub-national levels equally across prevention, access to quality treatment and social reintegration of survivors?
- c) To what extent has MHTF been an effective platform for the global Campaign to End Fistula?

Evaluation Criteria

Relevance, effectiveness, efficiency

Rationale

Obstetric fistula is caused by prolonged obstructed labour and is an extreme consequence of poor access to basic emergency maternal health care. Once fistula occurs, surgical repair is the only option. Surgical skills needed draw across disciplines (gynaecology, urology, general and plastic surgery, in some cases also gynaecology). Recovery time is protracted and not certain. Post recovery, women and girls may not be able to return home and, in most cases, may need a range of social protection support. Obstetric fistula is thus a complex development problem that has multiple dimensions. MHTF aims to support countries to take steps to prevent and respond to fistula and similar conditions to reduce maternal emergencies, save the lives of newborns, and improve quality and availability of care. Fistula incidence reflects proximity and use of emergency obstetric care (EmONC) and referral capacity making prevention part of a comprehensive maternal health strategy. Post fistula repair depends, to some extent, on identifying sufferers and connecting them with services. Post fistula recovery depends on a multi-sectoral approach to well-being, employment and skills, social reintegration and other factors. As fistula is still poorly understood and sufferers are hidden, data needs to be treated carefully as increasing numbers could be a sign of improved service response rather than increasing incidence. Although it has its own fistula aims, the MHTF also hosts the global Campaign to End Fistula which works with a mandate from the UN Secretary General & UN Member States to end fistula in 55 countries. The Campaign is largely merged with the MHTF goals on fistula but reaches beyond the scope of the MHTF and brings its own funds to bear.

Assumption 4.1: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, support is consistent with strengthened government leadership and capacity at national and sub-national levels to develop, implement and monitor costed and time-bound national strategies for preventing and treating fistula

Indicators:

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<ul style="list-style-type: none"> • Development of costed time-bound national and sub-national strategies that set out meaningful prevention, treatment and recovery objectives and strategies. • Examples of implementation of plans and progress rolling out plans to sub-national and community levels • Fistula indicators incorporated into the HMIS at national and sub-national levels • Monitoring arrangements in place for fistula strategies across the three dimensions (prevention, treatment, recovery) • Examples of policy dialogue and development between national and sub-national health authorities especially around linking to EmONC networks • Examples of engagement with communities around fistula prevention and management, for example, maternal emergency transportation plans • Trends in the identification fistula cases • Examples of investments in preventing, treating and supporting recovery from fistula • Establishment and operation of programmes for staff training to implement strategies (surgery and nursing and community health workers). • Number of fistula repairs undertaken • National and local systems incorporate multisectoral engagement to address fistula, for example with nutrition, social protection, employment and training sectors. 	
Observations	Sources of Evidence
<p>National Fistula Strategy</p> <ul style="list-style-type: none"> • UNFPA and USAID fistula care plus project through the national Fistula Technical Working Group is supporting the review and costing of the fistula strategy to align to the national and international policies and strategy documents including the Health Sector Development Plan, the Vision 2040 and the SDGs. There is continued awareness creation and visibility of Fistula at national, district and community levels including fistula walks and commemoration of the National fistula day. There is a downward trend in reduction of the estimates of the prevalence of fistula as indicated in the UDHS surveys. This has been possible through support from UNFPA and key Global and National partners including USAID/Fistula Foundation, AMREF, Terrewode, World Vision, Women at Work International (WAWI), Medical Teams International (MTI) and Uganda Village Project have been fundamental in this Campaign and progress towards eliminating fistula in the country. 	UNFPA Uganda, 2018 MHTF Annual Report, 2018
<ul style="list-style-type: none"> • “The Obstetric Fistula strategy 2020/21-2024/25 was revised and approved. The strategy aligns to the national and international policies and strategy documents including the Health Sector Development Plan-II, the third National Development Plan (NDP III), the Vision 2040 and the SDGs. The strategy’s mainly focuses on strengthening the integration of fistula repair as a routine service and practice at the National, Regional and selected General hospitals across the country shifting from the camp-based mode of repair and treatment.” 	UNFPA Uganda, Final Annual Report for MHTF, 2020, p.3
<ul style="list-style-type: none"> • “MHTF was captain in the area of fistula – because they supported the national fistula strategy -- the revision. The new strategy gives more focus on shift from camp-based repairs to more facility based routine repairs. Of course, that is quite a big dream. We have reviewed our HR structure to allow for specialists (obstetricians, paediatricians and others) at general hospitals. So now that we have specialists and the general hospitals, we can start building their capacity in fistula repairs – because it is very specialized. Obstetricians etc. cannot do fistula repairs without extra training and skills development.” 	Interview, MoH Uganda, May 2021

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<ul style="list-style-type: none"> UNFPA (MHTF) funded the fistula strategy revision. The development of the revised strategy included technical inputs from WHO, UNICEF, USAID, AMREF and Medical Teams International (MTI). USAID used to be the main donor for fistula through EngenderHealth, especially for camps and outreach; however, this shifted in 2018 with EngenderHealth phasing out its support. UNFPA has scaled up to ensure that there are more partners, such as AMREF and MTI. 	
<p>UNFPA leadership and Fistula TWG</p> <ul style="list-style-type: none"> UNFPA is considered the main partner for MoH on fistula and has provided leadership on policy development: “For the one (i.e. fistula strategy) that just came out, UNFPA has provided leadership to the MoH, and of course also with the TWG. UNFPA has also organised annual fistula days in Uganda, by bringing together the TWG, and by funding part of the activities. Other partners also support us, but UNFPA has provided leadership in that.” 	Interview, NGO partner, Uganda, May 2021
<ul style="list-style-type: none"> UNFPA provided support to enhance the function and operations of the National Fistula Technical Working Group (TWG), which held 3 quarterly coordination meetings, a virtual commemoration for the International Day to End Obstetric Fistula and sensitization and mobilization campaigns for fistula. UNFPA supported the Fistula TWG to develop and approval a set of National Fistula management HMIS documentation and reporting tools, such as: <ul style="list-style-type: none"> OB/Gyn and Fistula Theatre register Fistula Care register Treatment and Follow-up register Registration form for documenting clinical notes and monitoring of care “To improve data quality, working with AMREF, UNFPA supported printing of Fistula Registers data quality assessment and Validation in at least seven selected districts to improve the quality of data. Data reviews of Repairs have also been incorporated into the Regular reviews to monitor implementation of the Strategy. (p.8) 	UNFPA Uganda, Final Annual Report for MHTF, 2020
<ul style="list-style-type: none"> UNFPA supports the technical working group on fistula. “Fistula is sometimes “orphaned” by the number of partners/donors supporting – when a donor leaves, it leaves a gap.” But at least the MHTF has been able to support the TWG that has been a platform for resource mobilization, but also working together to standardize work, and see what the other partners are doing across the country. “Through the TWG, at least we are able to map out who is doing what across the country – in terms of fistula – and the MoH. But also, it is a platform where the MoH sometimes expresses the needs that are there and need to be covered, and through that, it has been able to show gaps, through that, get different partners to come and step in.” It is also a platform to enable the MoH to express their needs. This was especially important in 2020 to ensure that fistula repair services continued during COVID-19 through the provision of PPE and commodities. Shifting from camp based to routine-based fistula care and treatment is challenging as it requires continuous training/capacity building of health care providers to be able to perform fistula repairs, as well as significant investments in infrastructure, equipment and infrastructure. 	Interview, UNFPA Uganda staff, May 2021
<ul style="list-style-type: none"> The overall goal of the FTWG is to ensure harmonized acceleration of prevention, treatment and social re-integration services for fistula under the overall framework of the National Obstetric Fistula Strategy; and leadership of the MoH. It will be led by 	MoH Uganda, Terms of Reference for the Fistula

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<p>the clinical department at MoH, which serves as secretariat of the FTWG. The FTWG will meet not less than once every three months</p> <ul style="list-style-type: none"> • FTWG outputs include (but are not limited to): Policy proposals (including strategies, guidelines, standards, etc.) for quality delivery of fistula interventions, in line with the National Obstetric Fistula Strategy, Roadmap for Accelerated Reduction of Maternal and Neonatal Mortality & Morbidity in Uganda, and Adolescent Health Policy; Fistula components for relevant sector policy and strategic documents, plans and programmes in particular the HSSIP; MoH Annual Work Plans and Budget Framework Papers; improved coordination of state & non-state actors aligned with National Obstetric Fistula Strategy; increased mobilization and leveraging of resources for fistula interventions; increased coverage of fistula care services; harmonized criteria for training teams, calculating costs, etc.; quarterly fistula partnership forum meetings; harmonized recommendations relevant for prevention, care, treatment, and reintegration; and identification and utilization of best practices. 	<p>Technical Working Group, Undated</p>
<p>Reported progress in 2019:</p> <ul style="list-style-type: none"> • Fistula coordination • Conducted quarterly Fistula Technical Working Group meetings in Q3 and Q4. • Conducted supportive supervision visits to repair camp sites in Q4 • Commemorated the IDOF and Fistula Walks in Q2 to raise awareness • Strengthened national capacity for obstetric fistula management: • Q4: 11 hospitals (Mulago, Arua, Lacor, Hoima, Soroti, Mubende, Mbale, Mbarara, Kisiizi, Kitovu and Terrewode) conducted repair camps (total: 339 cases). No activities held in prior quarters. 	<p>UNFPA Uganda, GoU/UNFPA Country Program Support to MoH 2019 Annual Workplan, 2019</p>
<p>Reported progress in 2018:</p> <ul style="list-style-type: none"> • UNFPA supported fistula coordination, including four quarterly TWG meetings and one ad hoc review of the Fistula strategy, chaired by the Commissioner Clinical Services. Draft Validated Fistula Strategy (2019-2024) was presented to Fistula technical working group and forwarded to the Senior management for approval in 2019. 	<p>UNFPA Uganda, UNFPA-MoH Annual Workplan Progress Report, 2018</p>

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<p>Indicators:</p> <ul style="list-style-type: none"> • Increase in reported progress in all stages of fistula prevention, diagnosis, repair and recovery • Guidance available to health workers including midwives (prevention, diagnosis), surgeons (repair) and community health workers (prevention and recovery) • Policies and programmes in place to support rehabilitation of fistula survivors • Trends in number of fistula survivors who benefit from rehabilitation and reintegration programme and support. • Examples and of Community engagement and advocacy regarding the causes and consequences of fistula

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<ul style="list-style-type: none"> • Examples of changing community and health worker attitudes towards fistula sufferers and survivors • Documented multisectoral approaches which include life skills, nutrition, and social protection especially in the recovery phase • Examples of concrete integration of fistula strategies into EmONC and maternal health plans and approaches. 																	
Observations	Sources of Evidence																
<p>Need for fistula treatment services</p> <ul style="list-style-type: none"> • Findings from this 2020 study of data from the Ugandan DHS (2016) suggests that Uganda has a big backlog of women to treat for obstetric fistula and there were less women treated than expected in skilled healthcare centres. Although still under the expected figure, the benefit of these treatments for obstetric fistula is that for every one woman treated, eight more would seek treatment for the condition. This would however cost the country a great deal in that the treatment funds would perhaps give more returns if diverted to outreach activities aimed to get women seek skilled health- care during childbirth. • The authors estimate that the current lifetime prevalence of vaginal fistula symptoms in Uganda is between 16.3–22.5 per 1,000 women of reproductive age 15–49, putting Uganda highest among African countries. To reduce the prevalence of fistula in Uganda, 29 fistula centres were set up, distributed in 24 districts around the country. 	Nannyonga B and Singuli M, Modelling allocation of resources in prevention and control of obstetric fistula in Ugandan women, 2020, PLOS ONE, online																
<ul style="list-style-type: none"> • “In Uganda, women with fistula are living indicators of failed maternal and child health systems. The number of women suffering from obstetric fistula in Uganda is estimated at 1 per cent of women of reproductive age (UDHS 2016), reduction from 2 per cent (UDHS 2011), translating to range about 75,000- 120,000 women with the problem. The large backlog coupled with ever increasing new cases (1900 per year) has surpassed the existing capacity to repair the cases as we are able to repair between 1500-2000 fistulae every year.” 	UNFPA Uganda, International Obstetric Fistula Day 2020, 2020, p.3																
<ul style="list-style-type: none"> • The burden of obstetric Fistula in Uganda is estimated at 75,000 to 100,000 women with an annual incidence of 1,900 cases. 	MoH Uganda, Final Reintegration Assessment Report, 2019																
<ul style="list-style-type: none"> • “There is a downward trend in reduction of the estimates of the prevalence of fistula as indicated in the UDHS surveys. This has been possible through support from UNFPA and key Global and National partners including USAID/Fistula Foundation, AMREF, Terrewege, World Vision, Women at Work International (WAWI), Medical Teams International (MTI) and Uganda Village Project have been fundamental in this Campaign and progress towards eliminating fistula in the country.” (p.4) <table border="1"> <thead> <tr> <th colspan="4">Estimates of fistula in Uganda by UDHS</th> </tr> <tr> <th>Year</th> <th>2006</th> <th>2011</th> <th>2016</th> </tr> </thead> <tbody> <tr> <td>% Prevalence</td> <td>2.6% of women of reproductive age</td> <td>2.0% of women of reproductive age</td> <td>1.0% of women of reproductive age</td> </tr> <tr> <td>Estimated cases (Backlog)</td> <td>200, 000</td> <td>140,000</td> <td>75,000</td> </tr> </tbody> </table>	Estimates of fistula in Uganda by UDHS				Year	2006	2011	2016	% Prevalence	2.6% of women of reproductive age	2.0% of women of reproductive age	1.0% of women of reproductive age	Estimated cases (Backlog)	200, 000	140,000	75,000	UNFPA Uganda, MHTF Annual Report, 2018
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<ul style="list-style-type: none"> • 1,828 repairs were done for 2018 with support from partners, with 65 per cent (1,188) supported by UNFPA/MHTF funds. These camps and routine repairs were done in 21 facilities i.e. Mulago National referral, regional hospitals and selected 																	

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Private Not for Profit facilities. The camp-based repair campaigns may need to continue as the country progresses in implementation of the RMNCAH investment plan given the very large backlog of women with fistula.	
<p>Services via fistula camps</p> <ul style="list-style-type: none"> • Funds for Fistula Camps were disbursed to seven Regional Referral Hospitals of Arua, Hoima, Mbale, Mubende, Lira, Virika and Soroti Hospitals, and Mulago National Referral Hospital. During the camps, continued mentoring of new Fistula surgeons is ongoing to build capacity of local surgeons. • Supportive supervision visits were conducted to seven regional referral Hospital Fistula treatment sites in Q4 by the MoH Clinical Services Department to ensure quality services especially follow up and linkage services for the survivors and also to ensure continuity of services. • Fistula care training conducted in December 2018 for 26 Nurses and midwives from 13 Hospitals • Collaboration with National Medical Stores (NMS) to develop a local kit postponed to 2019 • Terrewode facilitated activities that supported assessment of 400 Fistula Survivors Community social re-integration identifying their individualized reintegration needs, prioritize and addressed them. Activities included: • Health facility level assessment in seven Hospitals by the psychosocial support staffs in collaboration with Health workers in the regional referral hospitals of Masaka, Mubende, Mbale, Arua, Lira and Soroti and Mulago National Referral Hospital • Community level assessments to identify survivors that have already been treated and discharged through village health teams (VHTs) and OFAAN members, a network of fistula survivors. 	UNFPA Uganda, UNFPA-MoH Annual Workplan Progress Report, 2018
<ul style="list-style-type: none"> • UNFPA Uganda achieved 100 per cent per cent of its workplan objectives for fistula, i.e., <ul style="list-style-type: none"> ○ Coordination: Conducted quarterly Fistula TWGs; conducted a round of supportive supervision to 8 repair camp sites; conducted commemoration of IDOF and Fistula Walks ○ Service delivery: Supported 11 hospitals to conduct fistula repair camps in Q4 for 339 fistula clients 	UNFPA Uganda, GoU/UNFPA Country Program Support to MoH 2019 Annual Work Plan, 2019
<ul style="list-style-type: none"> • “A total of 1,468 women have been treated in the National, Regional and selected general hospitals during the year of which over 60 per cent were directly supported by UNFPA and 16 health workers in the regional referral hospitals were mentored in fistula surgery. With this funding, fistula activities were monitored and tracked through the Quarterly coordination meetings and technical support supervision of the different Hospitals. • With funding from this programme, the ministry was able to hold a successful commemoration of the International Day to end Obstetric Fistula with a televised event of an Online Webinar on the National Television, Mass Mobilization campaigns to sanitize Communities about Fistula and the repair opportunities as well as the drop in repairs at Designated Sites (Hospitals)as well as the Repair Camps.” (p.4) • “UNFPA mobilized more resources from Sida under the UN Joint Programme on GBV and the EU-Spotlight initiative to support 18 Fistula repair camps by 14 Hospitals and social reintegration. The 14 facilities that conducted the fistula camps include the following: 1 National referral hospital, 9 Regional Referral Hospitals (RRH) and 4 General/ PNFP Hospitals. 	UNFPA Uganda, Final Annual Report for MHTF, 2020

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<p>However, due to COVID-19 pandemic prevention and control guidelines (set up by the Government/MoH) that limited movements and gathering of people, the planned fistula repair camps were delayed.” (p.8)</p> <ul style="list-style-type: none"> UNFPA estimates that in 2022 they will support 3,000 repairs so as to reduce the backlog. 	
<ul style="list-style-type: none"> “UNFPA support to fistula camps has filled a critical gap and helped women suffering from this condition, since fistula prevention, care and treatment is not part of the routine package of services at health facilities and, thus, not adequately funded by the government.” 	Interview, MoH Uganda, May 2021
<p>Capacity building for fistula treatment</p> <ul style="list-style-type: none"> MoH has the technical expertise and capacity at the national level – and they are supervising/mentoring the RRH – who has a lot of fistula experts. At the national RH down to the regional RH – so we have experts all over, very experienced all over the country. And we have some experts in private not for profit hospitals – like the big hospital in Gulu (St. Mary’s Lacor Hospitals). Transitioning to a routine model would require that you have the equipment, a team that is dedicated and there to do these operations. “A special theatre is not a “must” – but to keep this a routine, it would be nice to have the space – when the women come, you work on them as they come in – without disrupting other essential services. When you go to Kawempe National Referral Hospital – they are so busy doing emergency operations. When you have an emergency, you deal with that, rather than treating a patient who can wait for another women.” Not all obstetricians can do fistula repair; there is not a strong national training centre for fistula; most surgeons go to Ethiopia. A lot of learning comes in through the fistula camps given that very few dedicated centres that do just fistulae on a routine basis. Terrewode is a dedicated centre. Regional Referral Hospitals do not offer routine repair except for Mbarara Teaching Hospital. UNFPA MHTF supports that hospital through MoH – only repairs, not reintegration. 	Interview, UNFPA Uganda national staff, May 2021
<p>Service provider perspectives</p> <ul style="list-style-type: none"> The hospital started its fistula programme in 1990 by an Irish doctor who mobilized funds from the US, Ireland and other countries to support camps servicing 60 or more women at time. EngenderHealth provided significant support through the MoH for a comprehensive package of fistula prevention, repair and social re-integration, but the funding ended in 2017. UNFPA provides support to the hospital to organise fistula camps. Due to COVID-19, only one camp was organised last year, in October 2020. The funding covers awareness creation, transportation of the women to the hospital, feeding during hospital stay, materials and commodities, and the DSA of the fistula surgeons coming from other places. “The money was very, very helpful, because as you know, prices have gone very high here in Uganda. It helped a lot, especially in terms of paying for the transport of patients going back home.” UNFPA does not provide any funding for social reintegration in this site. “Adequate funds for reintegration is a big gap.” The main challenge in shifting from camp approach to routine services is lack of specialised fistula surgeons and other medical staff. To build capacity, they normally invite medical officers (MO) and nurses to come and assist the “specialist team” to learn from them how to repair fistulas, but also how to prevent iatrogenic fistulas caused by injuries during C- 	Interview, Private, non-profit service provider, Masaka District, Uganda, May 2021

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<p>sections. “Transitioning to routine repair would be better, so that the trainees could come here and learn. But we do not have sufficient funding to organize a workshop to train those “external” medical officers and interns.”</p> <ul style="list-style-type: none"> • There is a clear system for following up on women once they have left the hospital, i.e. through phone calls and a 3-month check-up. “The follow-up is done on the phone – we give them cards on discharge, with our numbers, we tell them, move with your card, when you get pregnant, move with the card. The card has all our phone numbers, my number, the nurse etc. They can call and tell us if they have more leakage, pain or other challenges, and then they can come back – or we direct them to nearest health centre (HC), and we talk with the HC, those nurses call us, inform us about the problem seen, and then we advise and help them have the treatment. If not helping, we ask them to come back, we have funds for that.” • Identification of women who need fistula repairs is usually through “mouth-to-mouth” – women who come back from fistula camps and have been successfully repaired, tell other women that the next camp is in 3 months. Health facilities also refer women with fistula to the different camp sites. Awareness and demand creation is also through national and local radio, community-outreach, and mouth-to-mouth. • According to the provider, the following are the trends in fistula: “The cases caused by obstetric labour are fewer, in those coming in today. It could be that most of them have been cleared, repaired by now. We do not find those cases who have had a fistula for long. Also, there are fewer patients who said we have had fistula for 15-20 years, it is no longer the story – that means that they get repaired earlier. Could be because the efforts we have made. Referral hospitals are more active, meaning there are less cases of obstructed labour. There is a conservative management now, if a woman in obstructed labour for 2 weeks, action is taken. Supervision and mentoring have improved. The only challenge we have is to reduce what we are having – that could be done with more training and skills development. We could and should teach others how to do safe C-sections.” 	
<ul style="list-style-type: none"> • Fistula repair should be routine; however, there are logistic challenges to do that – unique equipment and supplies, including tents. Support is also needed for reintegration. “We can treat three to five cases per week, but only if we hold off other surgeries (vasectomies etc.) – otherwise, we can only do camps. So normally, we do not do more than one to two per day. The women stay for long.” 	<p>Interview, Service provider, Kampala, May 2021</p>
<ul style="list-style-type: none"> • There are several barriers to routine fistula repairs. First, it is a resource heavy undertaking, and second, there are still issues of human resources. “We do not have fistula surgeons all over these places. Two, equipment, we do not have equipment all over these places, all the public facilities. Three, fistula affects the poor.” Women have to been given money to come, to stay two weeks in hospital, and to go back home again. And those two weeks, without personal economies, it becomes hard (i.e. no feeding). Resources are needed for 40 women, and that will be able to cover for commodities and supplies for the operations – then they can mobilize a team of fistula surgeons who can come and organize the camp – they bring in other surgeons from other facilities – there has to be a team of at least four to five people for one camp. So, when they collect those few resources, they can organize a camp. • At the national hospital, “a special theatre is not a “must” – but to keep this a routine, it would be nice to have the space – when the women come, you work on them as they come in – without disrupting other essential services. When you go to 	<p>Interview, UNFPA staff, Kampala. May 2021</p>

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Kawempe National Referral Hospital – they are so busy doing emergency operations,” as opposed to elective cases that can wait without any risk to the patient.	
Shifting focus to reintegration of fistula survivors <ul style="list-style-type: none"> The 2020 plan includes an intervention to support evidence-based social reintegration/rehabilitation for fistula survivors (costed plan, monitoring, reporting, cost-efficiency evaluation). According to the annual report, the obstetric fistula social rehabilitation programme is available and monitored; however, it is “run by CSOs and not yet integrated into the government structures. Evaluation of the reintegration programme was done to inform the new strategy.” 	UNFPA Uganda, Final Annual Report for MHTF, 2020, p.12
<ul style="list-style-type: none"> “Three service packages constitute fistula care, namely prevention, treatment and reintegration. Reintegration refers to a deliberate approach during which fistula survivors or those with fistula deemed incurable are given social, psychological, medical and economic support to enable them settle back into the community. Interventions are at facility and community level. The Community based reintegration package recommended by the ministry of health provides counselling, community sensitization, linkage to VHTs, economic empowerment, follow up, involvement of fistula champions and life skills training. At facility level, MoH recommends reception of clients, counselling, needs identification, psychotherapy, co-morbidity management, accommodation, financial support (feeding, transport fares), referral to CBOs, life skills training, information on income generation in addition to timely repair while at facility level. Despite these recommendations, implementation reintegration package has continued to lag behind as highlighted in The Mid Term review of UNFPA’s Campaign to End fistula, which further recommended more attention to reintegration with dissemination of good practices, lessons learned, challenges and opportunities for future programming.” (p.7) The MoH conducted an assessment to determine the status of implementation of the reintegration package and develop facility and community models for wider adoption in future interventions and advocacy by the MoH and its partners. A total of 11 health units participated in the assessment: Mulago National Referral Hospital, St. Mary’s Hospital Lacor, St Joseph’s Hospital Kitovu, and the referral hospitals of Soroti, Lira, Mbale, Jinja, Mubende and Fort Portal. Two community-based organizations participated: TERREWODE and Uganda Village Project (UVP). The reintegration package was guided by WHO reintegration principles and outlines services to be offered at facility and community levels and emphasizes the linkages between these levels. Results of the assessment included: <ul style="list-style-type: none"> A total of 4,813 fistula repairs took place across the participating facilities in the past 5 years, with TERREWODE contributing 34%. There are 279 staff involved in provision of fistula services, but only 20 per cent received some form of training on reintegration. Counselling, medical management and reception of clients were the best performed services at facility level, with over 75 per cent of clients receiving each or all of them. Skills support (20%), financial support (30%) and psychotherapy (30%) were received by the least number of clients. Only 13 per cent of respondents received more than half of the services in the facility package. 	MoH Uganda, Final Reintegration Assessment Report, 2019

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<ul style="list-style-type: none"> ○ The vast majority (89%) were satisfied with integration services at facility level while 55 per cent rated community-level services as poor or fair. Only Kitovu Hospital, UVP and TERREWODE were involved in reintegration services beyond the facility, with TERREWODE accounting for 70 per cent of clients supported at the community level. ○ The assessment recommended that: Individual and family counselling as well as community sensitization would go a long way in improving the psychological aspects of coping with fistula. Capacity building for health workers especially in the entire reintegration package would enable better quality of services. The capacity building should also stretch to the community where Village Health Team (VHT) members could play a critical role in follow up and community level psychosocial support. However, there is a limit to this as a lot of clients come from outside the catchment areas of the various facilities. At all levels, there is need to integrate as much as possible with other services.” (pp. 8-9) <p>Additional recommendations:</p> <ul style="list-style-type: none"> ● Relevance: <ul style="list-style-type: none"> ○ Efforts should be made to involve all ministries and other stakeholders with relevant roles to play in fistula reintegration ○ Reintegration programmes should be designed to socially, psychologically and economically benefit all patients. ○ Both facility and community reintegration should be strengthened because they have a significant and complementary role to play at different times during the reintegration process. ● Effectiveness: <ul style="list-style-type: none"> ○ MoH and other stakeholders should advocate for more resources to support reintegration, ○ Surgical care services should work hand-in-hand with other stakeholders to include reintegration ● Efficiency: <ul style="list-style-type: none"> ○ Clients should be oriented to needs identification and be given feedback about findings that exclude them from economic empowerment activities. ○ Clients should be given minimum start-up capital to ensure that resources can be spread among a larger number of clients ● Impact: <ul style="list-style-type: none"> ○ Increase male involvement through community sensitization ○ Strengthen linkages between health facilities and CBOs ○ To achieve sustainability, reintegration services must be integrated into the existing health care package and ownership by government and community enhanced. 	
<ul style="list-style-type: none"> ● “Most of the resources have been going to the repair to be done – and reintegration is one of the areas that still needs more funding, to see that this reintegration happens, across the board, including the public facilities. At the public facilities, that component is not strong – no funding. The PNFP have some small puts of funding – some pigs are given to the women, some skills building.” 	<p>Interview, UNFPA Uganda national staff, May 2021</p>
<ul style="list-style-type: none"> ● UNFPA has contributed to increasing access to fistula treatment and social reintegration through funding for fistula camps, support to develop the national fistula strategy, and funding of Terrewode for reintegration projects. UNFPA has supported the fistula technical working group (TWG) and fistula camps, as well as social reintegration (through the NGO Terrewode). 	<p>Interview, UNFPA Uganda staff, May 2021</p>

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<p>There is a huge funding gap for fistula – often considered the “orphan” technical area. Shifting from camp based to routine-based fistula care and treatment is challenging as it requires continuous training/capacity building of health care providers to be able to perform fistula repairs, as well as significant investments in infrastructure, equipment and infrastructure.</p> <ul style="list-style-type: none"> • Different partners support reintegration: therefore, MoH and UNFPA wanted to “standardize” this reintegration support as reintegration mean different things for different IPs. “It was important to develop a standard package, and review this package with MoH, to ensure when we talk about reintegration, we understand the same thing. Reviewing this package, what it entails, what it costs – will be a focus of this year (2021). It will also be a very good resource mobilization – if you have 50 women, how much will it cost to reintegrate them – it will be important and useful when we lobby for funds with our donors. I was excited myself to see that the Kitovu hospital, that we just visited, had some kind of reintegration. It is very thin on the side of the government facilities. At least we should have a minimum package. Even if you have repaired them successfully, they might still have psychosocial issues that need to be resolved, they will need a lot of economic support, to gain a living.” • MHTF support to Terrewode (East Region) is for reintegration – in both Kampala and the Soroti sites. (The surgery is done only in Soroti). The MHTF funds for Terrewode go through the MoH – not to Terrewode. “The work that goes in to having that understanding is with MoH – Terrewode is a small organization and has been at the forefront of coming up with these reintegration strategies. But I do not think they have ever applied to become an IP from UNFPA - the call went out, but they did not apply directly with us. For fistula, the funds only go to MoH – for reintegration (Terrewode) and camps (MoH sends to the hospitals).” 	
<p>Model for reintegration (and holistic fistula services)</p> <ul style="list-style-type: none"> • UNFPA has funded Terrewode, through MoH, for over a decade. UNFPA has supported both camps and reintegration (for the last 7 year). UNFPA has supported both prevention, treatment and care, and social reintegration, but they did not receive any UNFPA funds last year. This year, they are expecting to receive UNFPA funds through MoH for social reintegration only. • Terrewode has been active in fistula for the last 20 years, starting with awareness creation at community level, long before UNFPA began their programme. Collaboration was started with UNFPA in 2007 or 2008, when UNFPA started their country programme in Uganda. At first, collaboration was informal. All funding comes through the MoH, both for reintegration and camps. It has been a long-term relationship, but the MOU is not directly with UNFPA, but with MoH. Terrewode also received funding from EngenderHealth until 2018. The funding included research on how to support women who are “incurable”, i.e., cannot be cured for fistula (approximately 1 per cent) and it has some preliminary findings, not yet published. “These women are there now – we do not have funding to help them. It was a beautiful piece of work, it found out that social reintegration can help those women, but it requires more resources, more tailored approach, than those women who get treated.” • Terrewode uses a holistic approach to address the issues of obstetric fistula, which has been developed over time based on the experiences and lessons learned. “But we were not able to achieve all this, until we established the Terrewode Women’s Community Hospital providing care to mothers with birth injuries, obstetric fistula, different tears, prolapse etc. So it is specialised in providing that. We have two arms: Community outreach arm collaborating with health facilities and other partners like UNFPA to support community awareness, treatment and reintegration. The other arm, which is piloting some practicing for routine care – is it possible that you can provide routine services – how can it be done, what does it cost etc.?” 	<p>Interview, NGO partner, Uganda, May 2021</p>

Assumption 4.2: MHTF and UNFPA, including through leadership of the Campaign to End Fistula, have engaged with national leadership, to enhance ownership and accountability in ways that build <u>health systems, and community capacity</u> at national and sub-national levels across prevention, access to quality rehabilitation and social reintegration of survivors	
<p>We are still piloting that. We want to share with the other partners through the TWG for fistula. I think it will inform us which kind of resources you will need to provide routine fistula treatment and care. What does it cost, what impact can it have for the women who are treated and reintegrated, and also, does it actually increase the number of fistula experts in the country. We also hope to provide training to junior upcoming doctors, providing hands-on mentorship on very specialised aspects of fistula care and other birth injuries. But broadly, the NGO arm (the first arm) continues to engage communities on broadly maternal and child health. When you talk about obstetric fistula, but we also address the primary causes, the line causes, like teenage pregnancies, and how they can expose the teenagers and make them vulnerable, either they die in childbirth, or they have birth injuries. So, we provide a comprehensive package. We work with health facilities and VHTs, we are adding our contribution to national efforts (of the MoH) which are aimed at contributing to global efforts to improving health and SRHR broadly.”</p> <ul style="list-style-type: none"> • When asked about trends in fistula, the respondent, noted that patients come in earlier. Previously, there was a high number of women who have lived with the condition for more than 10 years. Cases are increasing among those who are handled within 12-24 months, and still a very few of those with very long-term conditions. 	
Assumption 4.3: MHTF is an effective platform to host the <u>Global Campaign to End Fistula, enabling harmonisation of strategies, activities, advocacy and financing to deliver results on fistula more efficiently than either approach would alone</u>	
Indicators: <ul style="list-style-type: none"> • Examples of increased political commitment, national leadership and ownership and financial mobilization linked to campaign activities (i.e., International Day to End Fistula, 23 May) • Examples of improved knowledge sharing and collaboration among global campaign partners. 	
Observations	Sources of Evidence
<p>UNFPA support for International Day to End Obstetric Fistula</p> <ul style="list-style-type: none"> • The theme of the 2020 International Day to End Obstetric Fistula (IDEOF) was “End gender and health inequalities; End fistula now.” Partners included USAID, WHO, AMREF, Fistula Care Plus (EngenderHealth), Terrewode, Medical Teams, Uganda Village Project and CoRSU. The objectives are to raise awareness about causes, complications, prevention and treatment of obstetric fistula; advocate for communities to support reintegration of fistula survivors; strengthen maternal health partnerships at all levels; and advocate for continuity of SRHR services amid COVID-19 pandemic. Activities included a live webinar broadcast on TV, Facebook and Twitter; radio advertisements and talk shows; spot adverts on TV, community sensitization using film vans and loudspeakers; printing and distribution of IEC materials, i.e., t-shirts, banners and flyers; and a newspaper supplement. • It was estimated that 500,000 Ugandans were reached via these activities. • Issues that arose: <ul style="list-style-type: none"> ○ Inconsistent and outdated data is still being used (2016). ○ Some facilities do not have formal data collection tools (HMIS) for fistula. 	<p>UNFPA Uganda, International Obstetric Fistula Day 2020, 2020</p>

Assumption 4.3: MHTF is an effective platform to host the <u>Global Campaign to End Fistula, enabling harmonisation of strategies, activities, advocacy and financing to deliver results on fistula more efficiently than either approach would alone</u>	
<ul style="list-style-type: none"> ○ Mothers were not accessing health facilities for EMOC services easily during the lockdown and lacked adequate transport means (ambulance). ○ Some HCIVs do not have functional theatres so mothers may have to move long distances to access C-section services hence contributing to the delays. ○ There is a gap in availability and access of some family planning methods in some health facilities contributing to unmet need of family planning and increased risk of fistula occurrence. ○ There are few skilled fistula surgeons, and this creates a backlog of fistula. ○ Late referrals from lower-level facilities contribute to the morbidity at CEmONC facilities including fistula occurrence. ○ Immediate follow-up action items included: printing and dissemination of data tools, on-site validation of data with DHIS, funding to improve transport, upgrading function of theatres in HCIV facilities to perform C-sections, increased support for family planning, additional training for skilled fistula surgeons (2 per every regional hospital), regular (quarterly) follow-up of facilities that delay referrals. 	
<ul style="list-style-type: none"> ● 2019 marked the 16th Anniversary year landmark of the Campaign to End Fistula, the purpose of which is to “enhance visibility; generate new ideas/evidence on obstetric fistula and also strengthen partnerships in the fight to move the fistula agenda.” (p. 2) The theme was “Fistula is a human rights violation – end it now.” The MoH in collaboration with UNFPA and other partners and stakeholders organized to observe the day in Rukungiri District, Western Region which has one of the highest numbers of fistula cases as per the Uganda DHS surveys from 2006, 2011 and 2016. Two private not-for-profit facilities, i.e., Kisiizi and Bwidi mission hospitals, and Kabale Regional Referral Hospital have the capacity to carry out fistula camps. ● One of the activity highlights was the State Minister for Health condemned child marriage and teenage pregnancies in the districts and called for new laws to address child and forced marriage and make parents and community leadership accountable. ● Recommendations and immediate follow-up actions included the need to expand the repairs to general hospitals so as to bring the services closer to the consumers and the need for routine fistula repair services (even though emergency services crowd out routine surgeries). 	UNFPA Uganda, International Obstetric Fistula Day 2019, 2019
<ul style="list-style-type: none"> ● The International Day to end Obstetric Fistula celebrations were held on 23 May in Kibuku district under the theme: “End Fistula Now: Reach Every One.” A week prior to the event, UNFPA and partners supported a fistula camp which saw 25 women from the region get free repairs at Mbale Regional Referral Hospital. A fistula march organised by WAWI consisting of survivors, students, local NGOs and CSOs, politicians and other stakeholders was part of the occasion in Kibuku town. 	UNFPA Uganda, UNFPA-MoH Annual Workplan Progress Report, 2018

Area of Investigation 5: Integrated SRHR

Evaluation Question 5: To what extent has the MHTF contributed to strengthened integration between maternal health and sexual and reproductive health (with a focus on family planning, post-partum family planning, post-abortion care and safe abortion care (where legal); cervical cancer prevention; PMTCT, and SGBV to achieve quality service delivery, to increase client satisfaction and to stimulate greater public demand for SRHR services?

- How and to what extent has UNFPA **advocacy** for strengthened integration between maternal health and SRHR resulted in adoption within various strategies and initiatives at global, regional and national level?
- To what extent have UNFPA-supported **models and approaches** for linking MNH and SRHR been implemented at national level within health service delivery settings (supply) and behaviour change and communication efforts (demand)?
- To what extent has UNFPA supported **integrated programming and synergies within MHTF** (across the four core technical areas) and with **other UNFPA technical areas** (UNFPA Supplies, SRHR, Gender, Youth, etc.)?

Evaluation Criteria	<i>Relevance, effectiveness, efficiency, coordination</i>
Rationale	In order to support women and adolescent girls across their lifespan, there needs to be in place a continuum care from sexual and reproductive health through to pregnancy and the postnatal period and wellness across all stages. Women and newborns are at the highest risk of death and morbidity during labour, childbirth and in the first week after birth. The MHTF aims to support countries to address the “three delays” in accessing quality maternity care and improving the post-partum or post-abortion period. The MHTF supports countries to strengthen access to and the quality of ANC, with special attention to adolescent girls and youths. The ANC package includes essential sexual and reproductive health information and services, such as for the prevention of unsafe abortion, access to safe abortion (where legal) and the prevention of mother-to-child transmission of HIV.

Assumption 5.1: UNFPA is active in advocacy for the full integration of SRHR and MNH into health systems, national strategies including UHC and other platforms and for initiatives that strengthen linkages between MNH and SRHR within global, regional and national strategies and plans

Indicators:

- MNH services **integrated into PHC and UHC protocols**, approaches, Global Financing Facility (GFF) investment cases and SDG3 GAP process, where applicable
- Examples of **MHTF leadership** for ensuring global and regional attention to MNH-SRHR integration within global initiatives, (such the Global Strategy for Women’s Children’s and Adolescents’ Health, the ICPD 25 Nairobi business, and the SDG 3GAP process)
- GFF investment cases** (where applicable) include a full complement of SRHR and MNH services.
- Activities in countries **linked to the Global Action Plan initiative**
- National health sector strategies and plans incorporate linkages and integration** of MNH and SRHR, including post-partum contraception, postabortion care, safe abortion care (where legal), cervical cancer prevention, preventing mother-to-child transmission of HIV (PMTCT))
- Views of partners and stakeholders on the **role of UNFPA leadership on progress toward integration** with global, regional and national strategies and plans.

Observations	Sources of Evidence
<ul style="list-style-type: none"> The CP8 contributed to the UNFPA Global goal of the Strategic Plan, 2018-2021, which was to “achieve universal access to SRH, realise reproductive rights, and reduce maternal mortality to accelerate progress on the agenda of the Programme of 	UNFPA Uganda, GOU/UNFPA 8th Country

Assumption 5.1: UNFPA is active in advocacy for the full integration of SRHR and MNH into health systems, national strategies including UHC and other platforms and for initiatives that strengthen linkages between MNH and SRHR within global, regional and national strategies and plans	
<p>Action of the International Conference on Population Dynamics. This was to improve the lives of women, adolescents and youth, enabled by population dynamics, human rights and gender equality”. The CP8 pursued four programme outcomes in the areas of SRH, AY, GEWE and PD. The SRH component had three outputs namely: (Output 1): national and District Local Governments (DLGs) have the capacity to deliver comprehensive high-quality maternal health services, including in humanitarian settings, (Output 2): national and district governments have the capacity to increase the demand for and the supply of modern contraceptives; and (Output 3): increased national capacity to deliver integrated SRH and HIV/AIDS prevention programmes that are free of stigma and discrimination. The AY component had one output which was about increased national capacity to conduct evidence-based advocacy for incorporating adolescents and youth SRH needs in national laws, policies and programmes, including humanitarian settings. The GEWE component was expected to strengthen the capacity of national and DLGs for the protection and advancement of reproductive rights, and delivery of multi-sectoral gender-based violence (GBV) prevention and response services, including in humanitarian settings. The output of the PD component focused on increasing the capacity of national institutions and district governments for the production and use of disaggregated data on population, SRH and GBV for the formulation and monitoring of evidence-based policies, plans and programmes, including in humanitarian settings. (p. 13)</p> <ul style="list-style-type: none"> • Integrated and holistic programming is required to address the high teenage pregnancy rate, standing at 25 per cent. UNFPA recognizes there are causal pathways between GBV, SRHR and HIV. For example, a significant proportion of pregnant women report experience of violence and were more likely to develop obstetric complications such as hypertension and premature rupture of membranes. It was also evident that child marriage and teenage pregnancy increased the risk of STIs, HIV/AIDS, cervical cancer, gender-based violence, persistent and enduring inequalities, social stigma and isolation. 	<p>Programme Evaluation Report, 2020, p.13</p>
<p>Policy support for integrated SRHR</p> <ul style="list-style-type: none"> • The National Policy for Sexual Reproductive Health and Rights, which has been under review was approved by Top management of MoH. However, the element of delivering family planning services to adolescents/young people under 15 years of age still poses a challenge. The Uganda Demographic Health Survey (UDHS) 2016 results showed that Uganda still has high teenage pregnancy rate at (25%) and 48% of Uganda’s population is aged 0-14 years. As the country strives to improve family planning utilization and uptake, the sexually active adolescents should be brought in context to avoid associated consequences. The MoH in partnership with UNFPA has trained Trainer of trainers from MoH, districts, implementing partners both in Humanitarian and development in Minimum Initial Service Package (MISP) for SRH and clinical care prevention and management of GBV survivors. The training underscored the need for integration and provision of quality Emergency Obstetric and Neonatal care services to reduce on maternal and newborn morbidity and mortality. Advocacy for inclusion of MISP in pre-service training in curriculum of medical schools, Tutor colleges and midwifery schools was done through meetings with the heads of training in MoES, tutor college principals and Deans of the schools of Health sciences, public health in Makerere University. 	<p>UNFPA Uganda, 2018 MHTF Annual Report, 2018</p>
<p>Policy support for integrated Adolescent SRH</p> <ul style="list-style-type: none"> • In an effort to create an enabling environment, the review process for the ADH policy is almost complete which involved addressing recommendations from the MoH senior management based on the results from the Landscape analysis and the 	<p>UNFPA Uganda, 2019 MHTF Annual Report, 2019</p>

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<p>Regulatory Impact Assessment (RIA). The draft policy will then be presented to stakeholders for additional input, and subsequently to Senior Management of the MoH for approval.</p> <ul style="list-style-type: none"> • UNFPA will build on the current political will, and the newly established high level multi-sectoral ADH Think Tank to fast-track the process. Establishment of the ADH Think Tank will provide a platform for discussion and providing solutions to the SRH challenges faced by young people through an evidence-based, holistic and multi-pronged approach. Led by the MoH Minister of State for General duties, it comprises of leading MoH senior technical managers including the Permanent Secretary and Director General; national ADH professionals/experts and influential persons; and representatives from the key sectors, international agencies and the youth. UNFPA will continue to strategically influence the discussion agenda, as well as providing technical assistance to the MoH to facilitate accelerated decision making regarding key issues. National Youth Engagement Strategy on SRHR: Harmonization of this strategy with the Uganda National Parenting Guidelines was completed, on the recommendation from the MGLSD senior management. Approval of this strategy will enhance a multi-sectoral approach and meaningful participation and engagement of adolescents and youth in sexual and reproductive health programmes in the country through the proposed coordination structure. Use of the evidence and platforms highlighted above will increase space for advocacy for improved SRHR programming for adolescents and youth. 	
<ul style="list-style-type: none"> • With support from governments of Netherlands and Austria, UNFPA supported implementation of the quality improvement approaches both at national and sub-national to ensure better health outcomes, by addressing quality gaps in the delivery of ANC, labour and delivery, postnatal and newborn care services. At national level, UNFPA supported the Revision of the National Quality improvement strategy and Framework 2020- 2025 and the finalization and launch of the Patient’s charter on the World Patient’s Safety Day commemoration. • UNFPA also supported MoH to update the QI training packages and trained 50 National and regional Trainers. At the sub-national national level, UNFPA supported training of health personnel in quality improvement in maternal health, family planning, post abortion care and SGBV screening and treatment. Additionally, personnel have been trained on data management, capture and analysis in relation to Quality Improvement (QI). With funding from MHTF the UNFPA was able to provide technical support during the development of the National Quality Improvement Strategy and Framework. 	UNFPA Uganda, 2020 MHTF Annual Report, 2020
<p>Development partner perspectives</p> <ul style="list-style-type: none"> • When UNFPA was asked to show what they are doing at the field level to ensure coordination among IPs, it seems that they organize separate meetings by technical partners rather than bring together the partners who are complementary, all contributing to a common goal. This seems to indicate that the field staff do not manage via an integration philosophy; it is an out-put based management process. A strong integration approach would track in how activities are managed. • The implementation/operationalization of a comprehensive, integrated package of SRHR services may still pose a challenge in some sub-regions, depending on the capacity of UNFPA to coordinate multiple IPs, implementing different technical areas/components of the programme at the sub-national level. 	Interview, Bilateral donor, Kampala, Uganda, May 2021
<ul style="list-style-type: none"> • “I can clearly see UNFPA as a convening partner, bringing together several stakeholders from different institutions. It is impressive how they brought together all those stakeholders, commissioners, ministries for integrated SRHR, GBV and HIV. To get that commitment of government, to actually show up, and to make commitments; it was a good thing they did, and quite 	Interview, Bilateral donor, Kampala, Uganda, May 2021

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impressive and a key achievement. UNFPA has established itself as a key institution on SRHR, talking about adolescents, family planning, etc. When you talk about those topics, you immediately see a strength here. "	
<ul style="list-style-type: none"> • MHTF works to support integration, equity and quality. The MoH plays a key role on integration and UNFPA supports the development of guidelines and now the investment case. 	Interview, Bilateral donor, Kampala, Uganda, May 2021
<ul style="list-style-type: none"> • UNFPA tends to work in a vertical way, i.e., pushing for a family planning costed implementation plan, when the government wants an integrated CIP across the RMNCAH continuum of care. The FP-CIP should be part and parcel of an overall investment case, as a FP strategic plan. 	Interview, Multilateral Partner, Kampala, Uganda, May 2021
<ul style="list-style-type: none"> • "Our comparative advantage is integration. When you strengthen one cluster, you strengthen the other, and hence, you strengthen the whole system. Linking MNH with SRH and GBV is the way to go." • "UNFPA is a small contributor to MNH; therefore, you have to integrate, integrate, integrate." 	Interview, UNFPA Uganda national staff, May 2021
<p>Supporting integration through routine coordination</p> <ul style="list-style-type: none"> • UNFPA supports the MoH to strongly move the integration agenda, because most of the programmes have been supported in a parallel way (in the past). A number of efforts have happened over the last two years to support data management tools for integration in the national HMIS system. For example, PFP and FP in PAC were not integrated in the HMIS primary data and reporting tools; one can now track the data of how FP is integrated into ANC, PAC; even immunizations. • Also, UNFPA supported the MoH (through the MCH cluster and the Commodity Working Group) to have a national CQI framework that includes PAC and PFP tools. The platform is now functional. • UNFPA Uganda organizes its SRHR work in an integrated fashion, e.g., MHTF advisors (MH team) sit within Department for Integration of SRHR (includes ASRHR, HIV/GBV/SRHR integration team, FP): <ul style="list-style-type: none"> ○ Fosters close collaboration and exchange ○ MHTF-supported advisors provide technical assistance to support integration of maternal health within other programmes/proposals ○ Successfully integrated MH in Sida GBV Joint Programme and ANSWER project 	Group discussion, UNFPA Uganda national staff, May 2021
<ul style="list-style-type: none"> • UNFPA advocates for integration from global level to country level; however, programming is not always focusing on integration, "so it has been a slow walk to understand where to put your next foot on firm ground." In 2009/210, UNFPA supported MoH to apply the Global Integration Tool to generate some evidence for MoH and used the findings to support MoH to develop the first strategy (around 2012). This has made some small steps in getting partners, especially on HIV platforms, to integrate, even faster than the SRHR platforms. In 2016-2017, UNFPA supported the revised integration strategy, but unfortunately could not take it through the approval process. It was the same time that the MoH refused to sign off the overall SRHR policy guideline. The MoH did not approve a lot of other strategies, including the comprehensive condom programming strategy. In 2019, there was a breakthrough as the MoH top management agreed that the SRHR policy guideline should provide for provision of SRHR services to adolescent, age 15 and above. This applied to the other documents, including the integration strategy; it is now pending again at senior management. There is good political will, the current PS is supporting integration – but more from the UHC perspective – but UNFPA successfully advocated to use SRHR as 	Interview, UNFPA Uganda national staff, May 2021

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entry point. The PS also approved the “SRHR, GBV, HIV Steering Committee” which was established in 2018. As far back as 2016, the MoH established a technical task team on this integration. It was supposed to be chaired by Director for Clinical Services, but it is now delegated to Assistant Commissioner SRHR, which should ideally bring on other sectors, like gender, CSOs etc. It is the team that UNFPA uses to review concepts for clearance before they are implemented. It is the same team that supports the Sida funded 2gether4 SRHR.

- **The sharpened plan (i.e. the new RMNCAH investment case) is currently in development** – there is a review process in the final stages. The integration assessment revealed that the biggest challenge is that there are many vertical programmes. There are challenges with integrated supply chain systems – the HIV and SRHR commodities still flow through vertical systems.
- UNFPA has worked on HMIS/DHIS2, “in 2016 we worked on HMIS indicators, to see **how we can track integration**. In 2019/2020, we managed to have **a few integration indicators on the DHIS2 platform** – we have managed to have some, not all, to assist us having integration indicators – e.g. in facility X, client Y received 2 services (but we still do not have possibility of saying that a client received more than 2 services). Some progress has been made.”
- UNFPA also participates on HRH platforms. “**HRH is the elephant in the house**. It makes it more complicated to advocate for a smaller piece – like SRHR, GBV, HIV integration. We have reviewed pre- and in-service tools for integration, and partially used the results differently, e.g. WHO is supporting curricula review for pre-service. We also made input into the HR strategy that is running. But since the problems are at macro level, getting to one piece, becomes a bit challenging. We are working on mentorship and supportive supervision – with a focus on integration – this is linked to HR platform. We developed an **“integration scorecard” which uses DHIS2** but also data from facilities (when not reporting in HMIS/DHIS2). At the (SRHR) conference (UNFPA organised a large multi-stakeholder conference focusing on SRHR, HIV and GBV integration in February 2021 – with Sida-funding), the outcomes of the tool were shared. UNFPA supports the in-charges and health workers to use the scorecard, go through gaps in skills sets, working with regional referral hospitals to do the skills training and mentorship on integration.”

Assumption 5.2: Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services

Indicators:

- National health authorities confirm adoption/adaptation of **evidence-based models and approaches for integration** of MNH and SRHR, including but not limited to post-partum family planning (PPFP), post-abortion care (PAC), safe abortion services – (where legal), PMTCT
- Operational guidelines for health services staff include **protocols for integration** of MNH and SRHR information, services and referrals
- Reported results from UNFPA-supported **programmatic interventions** to pilot, adapt, or scale-up integration models and approaches (PPFP, PAC, PMTCT, etc.)
- Reported results from efforts to expand **ANC package for essential SRHR information** and services for adolescent girls and youth
- Reported **experiences and views** of selected national health authorities and implementing partners on progress and challenges related to integration of MNH and SRHR.

Assumption 5.2: Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • “We have made good progress with our integration approach – linking MNCH activities with FP and GBV. It is a steady progress. That is the purpose of our field support unit at the country office level and our field presence through the 7 field offices. Hopefully it ensures a strong anchoring of UNFPA at the district level. The biggest advantage is the ability to implement this within humanitarian settings.” 	Interview, UNFPA Uganda national staff, May 2021
<ul style="list-style-type: none"> • At the policy level: UNFPA Uganda has played a lead role in promoting and advancing the policy agenda for integrated SRHR, HIV and GBV. In the past, most success has been in advocating for integration of SRHR and GBV into existing HIV platforms and programmes. UNFPA played a lead role in advocating for and developing SRHR, HIV and GBV integration policy, but its approval has been pending for some time, due to the pending approval of the overall SRHR policy, which guides all other SRHR strategies and plans. UNFPA played a lead role in supporting the MoH to establish national coordinating platforms for integrated SRHR, HIV and GBV. • At the operational level: UNFPA advocates (with government and their donors) for the delivery of “an integrated package of rights” which means they try to use all their funding streams (i.e. for FP, HIV, SRHR, GBV, MH) to ensure that the end-user receives an integrated package of SRHR/MNH services. If UNFPA does not have funding to cover for all those services, they encourage their IP to use other funding sources they may have, to complement the package. Example: Provision of integrated package of outreach services (i.e. health services taken to hard-to-reach communities at special outreach days). Some progress has also been made to support the MoH to develop indicators to track integrated service delivery at facility level, although seems limited. 	Interview, UNFPA Uganda national staff, May 2021
<p>West Nile and Acholi ASRHR assessment</p> <ul style="list-style-type: none"> • In July-August 2020, Marie Stopes Uganda conducted a facility assessment exercise in 130 public health facilities in West Nile and Northern Uganda to determine health system gaps that need to be addressed to enhance SRH service delivery, in particular EmONC, family planning and post-abortion care services. • Highlights included: <ul style="list-style-type: none"> ○ Only 18 per cent (47) of the assessed 254 service providers scored competency level one in counselling for a full range of FP services including both short term and LARC services. ○ Only 15 per cent of assessed service providers scored competency level one in infection prevention. ○ Only 6.3 per cent of assessed service providers scored competency level one in stock management. ○ According to an assessment report for adolescent SRHR, MVA (Manual Vacuum Aspiration) procedure for incomplete abortions under 12 weeks of gestation are mostly done in HCIVs and hospitals. The lower facilities (HCIIIs and HCIIIs) do not have staff with skills to perform the procedure. In districts where providers had received a training by an Implementing partner (i.e., Pakwach, Moyo), they did not receive MVA equipment and, therefore, lost the skills. In Lokung HCIII in Lamwo district there were MVA kits in the Maternity section, but three new kits had expired in the store. In Besia HCIII in Moyo, the In-charge bought new kits last year but has never been used as the midwives lack the skills and confidence to do the procedure. In Madi-Opei HCIV facility in Lawmo District, there has been an increased trend in 	UNFPA Uganda and Marie Stopes-Uganda, Narrative Assessment Report for Public Health Facilities for ASRHR – UNFPA Project in West Nile and Acholi Sub-regions, 2020

Assumption 5.2: Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services	
<p>adolescents inducing bleeding by going to a drug shop near the market, and then going to the facility to receive MVA from a senior midwife who is known to have skills.</p> <ul style="list-style-type: none"> ○ Providers also had knowledge gaps on client “profiling,” to establish their preferences in family planning, use of job aids (i.e., the WHO Medical Eligibility Criteria wheel, models for condom demonstration, IUD insertion) and providing method specific information to dispel myths and misconceptions. It was further noted that some IEC materials like MEC wheels, flip charts, uterine models were not available in some facilities. ● The report also noted that most providers have basic knowledge contraceptive implants, the site of insertion, the hormones in the implants and some of the side effects, especially bleeding. The gaps exist in skills to counsel and educate clients to explain on how implants work to prevent pregnancy and how to manage side effects. Clinical skills gaps include marking the sight for insertion, loading technique especially for Jadelle Implants and maintaining a sterile field during insertion. Approximately 90 per cent of facilities assessed did not have ready implant sets for use. Regarding IUDs, there is generally very low up take of IUDs in the region. This is partly be attributed to provider skills to provide Information and insert IUDs. Only 16 providers out of 254 assessed group were able to demonstrate correctly the steps of IUD insertion. Most gaps were observed in conducting a bimanual assessment to determine eligibility for IUD, the non-touch technique of loading the IUD and insertion into the uterus, could not give accurate and correct post-procedure information to clients. 	
<ul style="list-style-type: none"> ● A mapping exercise was conducted to inform the new “Advancing Sexual Reproductive Health and Rights in West Nile and Acholi Sub Regions in Uganda” Programme in West Nile and Acholi sub regions. “The mapping confirmed that the programme is suited to address its SRH and GBV challenges. Districts like Moyo, Amuru, Pakwach, Maracha, Madi Okollo, Nebbi and Zombo have very few IPs on ground, and they mainly invest on material supports (facility renovations, boda referrals, fuel for ambulances and few equipment procurement) to address SRH issues. GBV prevention and response is still a big challenge that needs to be considered in these districts while no relevant intervention is registered in this regard. The NL programme is an opportunity for UNFPA to utilize its experience in community- based interventions while delivering its integrated package or rights.” 	<p>UNFPA Uganda, Report on the mapping of the advancing sexual reproductive health and rights in West Nile and Acholi sub regions in Uganda, 2020</p>
<p>MNH-family planning integration</p> <ul style="list-style-type: none"> ● There was low availability of family planning services at health facilities. However, ANC, normal delivery and postnatal care service availability was above 88 per cent in all levels of health care. 	<p>UNFPA Uganda, Assessment of Quality Emergency Obstetric and Newborn Care Services in 25 Targeted Districts, 2017</p>
<p>UNFPA support to Uganda Private Midwives Association for integrated SRHR:</p> <ul style="list-style-type: none"> ● UNFPA supported UPMA to implement SRHR services in under-served areas in and conduct follow up and mentorship for private midwives who received midwifery kits from UNFPA. The activity was conducted in northern Uganda and Teso region and a total 20 private midwives’ facilities were visited and 20 midwives including co-workers mentored. ● UPMA also held a family planning training for 20 private midwives who during supervision were found lacking the required skills. The training was aimed at building capacity of private midwives to offer quality Long Term FP services especially in the under-served areas 	<p>UNFPA Uganda, 2018 MHTF Annual Report – Uganda, 2018</p>

Assumption 5.2: Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services	
<p>Support for guidance on PFPF</p> <ul style="list-style-type: none"> • The aim these “change packages” is to address the range of supply and demand barriers that affect uptake of PFPF services along the continuum of PFPF provision. These barriers require changes to happen at different levels of family planning service delivery. • The change packages will aim to address the following areas of improvement: <ul style="list-style-type: none"> ○ Family Planning counselling and education ○ Availability of quality FP services and provider skills ○ Integrating FP information and services in immunization ○ Data management and reporting for decision making ○ Strengthening community linkages ○ Availability of contraceptive methods 	<p>Unknown, Draft Postpartum Family Planning Change Package, Undated</p>
<p>UNFPA support for adolescent SRHR</p> <ul style="list-style-type: none"> • In order to prevent teenage pregnancies, child marriages and harmful practices, UNFPA is implementing a ‘Live your Dream’ Campaign targeting adolescents and young people basing on the fact that adolescent and young people have dreams and inspirations to act on and realize their dreams. A multi-channel approach is used to engage communities in dialogue to address factors that lead to exploitation of girls and young people and hence prevents them from attaining full potential. ‘Live your Dream’ campaign is premised on four pillars namely: live your dream by Letting Girls be Girls: addresses Gender Based Violence, access to Family Planning and prevention of teenage pregnancies; live your dream by Choosing Books before Babies: speaks to keeping girls in school, getting proper education about SRHR and avoiding teenage pregnancies and HIV; live your dream – With You(th): reflects UNFPA’s position as lead youth agency, unleashing young people’s potential, empowering for innovation and social change. With You(th) also showcases our work in humanitarian settings where we bring host communities and refugee populations together to build resilience by promoting SRHR; live your dream by bringing generations together (Generation for Generation - G4G), is about sharing the wisdom of the elderly with the energies of the youth, tapping on the insights of academia with the diversity of views of decision-makers in order to improve policies that affect Uganda's future. This signature campaign is meant to inspire action towards a better life for young people and women and promote the well-being of the entire family. Its objective is to inspire and support women and men, boys and girls, young and old to identify with UNFPA as the cutting-edge organization that addresses population issues in their entirety • UNFPA is also strengthening the functionalization of ELA clubs (Empowerment and Livelihood for Adolescents) model which integrates healthcare, encompassing reproductive health for boys and girls with livelihoods and economic empowerment sessions and targets youth between the ages of 10- 22 years mainly out of school and very vulnerable young people. The ELA clubs serve as safe spaces for adolescent girls, with a particular focus on girls who have dropped out of school or might otherwise be at risk of early pregnancy. The focus is on preventing and responding to effects of teenage pregnancy, increased use of contraceptives and menstrual hygiene, reduction in GBV and sexually transmitted infections. This supports girls to gain knowledge and confidence, enabling them to live safer, healthier lives. The primary aim of this model is to empower youth in achieving greater social and economic empowerment by implementing targeted interventions at individual, family and community levels on four assets: education, social network, health and economic empowerment 	<p>UNFPA Uganda, 2019 MHTF Annual Report Uganda, 2019</p>

Assumption 5.2: Evidence-based models and approaches to support programming for integrated MNH and SRHR service delivery promoted by UNFPA are adopted and implemented by national authorities for both supply of and demand for services	
<p>including life education skills, small scale business and entrepreneurship. This is made possible through a network of adolescent clubs led by trained adolescent leaders (Mentors). By implementing this model, girls and boys will be supported to access the various services: in education where life skills are developed; health where SRHR information, contraceptives and other services are provided, social asset building, and financial literacy.</p> <ul style="list-style-type: none"> UNFPA is also working with MoH to scale up an innovation called GetIN application aimed at increasing access to maternal health services by pregnant adolescents through timely identification and systematic follow-up of the girls in their communities. 	
<p>UNFPA reports of progress on integration</p> <ul style="list-style-type: none"> From the 2020 MHTF Results framework: Output 9 indicator – At least two SRHR components are integrated in more than 50 per cent of the EmONC facilities of the national network 9.1.a Proportion of women leaving the maternity ward of the EmONC facility with a modern contraception 28 per cent (DHIS II) 9.1.b Proportion of women receiving post abortion care and leaving the EmONC facility with a modern contraception 25 per cent (DHIS II) 	UNFPA Uganda, MHTF Results Frameworks, Indicators, Baselines and Targets, 2020
<p>Service provider perspectives on integration</p> <ul style="list-style-type: none"> “Our outreaches are integrated; we normally plan and do a lot of things, like ANC, FP, immunization, HIV testing, EID Exposed Infant Diagnosis, TB detection/samples, and adolescent services. At the facility, services are also integrated. When they come to OPD, they are also advised on family planning – she comes sick, but maybe she also wants FP – and the children are checked if they are due for immunization. Hepatitis B, TB etc. They are also screened and tested. We also screen for pregnancy in the OPD and ART clinic, and then referred if they are pregnant.” 	Interview, MoH service providers, Lawmo District, Uganda, May 2021
<ul style="list-style-type: none"> “Effective integrated delivery of services was however hindered by capacity gaps and skills among service providers on integrated SRHR/HIV and GBV services delivery, health systems challenges specifically on supplies stock outs and attrition/transfer of staff, unavailability of services at referral points, and inadequate human resource. Also, existing capacity to deliver services did not match with the demand that was created for services. Furthermore, there was no clear guidelines on integrated delivery of rights. The stakeholders were grappling with figuring out what an integrated package of services entailed and how to effectively deliver it.” 	UNFPA Uganda, GOU/UNFPA 8 th Country Programme Evaluation Report, 2020, p.27
Assumption 5.3: The MHTF was an effective programme to shape the overall strategic direction of UNFPA in relation to the integration of SRHR and MNH and has acted as a catalyst within UNFPA to build commitment to SRHR – MNH integration as a vital strategy	
<p>Indicators:</p> <ul style="list-style-type: none"> Evolution over time of coordination mechanisms within MHTF for ensuring linkages in programming and outcomes across the four technical areas, i.e., fistula, EmONC, midwifery and MPDSR Structure and operation of coordination mechanisms at global, regional and country level within UNFPA for ensuring linkages between MHTF and other areas of work, i.e., SRHR/the Supplies Partnership, SGBV/ gender, adolescents and youth etc. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> Refer to assumption 7.1 on MHTF as catalytic instrument for integration of MNH and SRH 	

Area of Investigation 6: Equitable and accountable access

Evaluation Question 6: To what extent has the MHTF contributed to strengthening the availability and quality of health service delivery and health information system to meet the diverse and differentiated needs of the women, newborns, and adolescent girls including in the lowest wealth quintiles, living in hard-to-reach areas, facing discrimination (based on identity, ethnicity, and/or faith) and/or living with disabilities?

Sub-questions:

- To what extent has UNFPA been effective in promoting and supporting national strategies and programmes, which consider the diverse and differentiated needs of women, newborns and adolescent girls, including the most vulnerable and disadvantaged?
- To what extent have national governments responded positively to UNFPA advocacy and technical support by allocating resources, altering policies, and implementing programmes that strengthen the supply and demand sides of care, ensure equitable and accountable access to quality MNH and SRHR services and that meet the needs of and empower women and adolescent girls?
- Have UNFPA-supported programmes have been effective in increasing the availability and utilization of MNH and SRHR services to women, adolescents and newborns, including the most vulnerable and disadvantaged?

Evaluation Criteria

Relevance, effectiveness, sustainability

Rationale

Globally, maternal mortality is the second largest cause of deaths among **adolescent girls** aged 15 to 19. Of all births globally each year, around 16 million (11 per cent) are among girls in this age range; about 2 million are among girls under the age of 15²⁸. Stigma, discrimination, judgmental treatment, lack of confidentiality, and inability to physically access services are important barriers to care for adolescent girls. The MHTF supports countries to improve access among adolescent girls to broader sexual and reproductive health services. Further, **poor women in rural and urban areas** and **minority women** have less access to quality maternal health care than wealthier women in urban areas. The MHTF supports their equitable access to MNH care and broader SRHR.

Assumption 6.2: UNFPA advocacy and technical support to national authorities focuses on the need to increase allocation of resources, adopt favourable policies, and strengthen accountability mechanisms to ensure equitable access to quality MNH and SRHR services that meet the needs of and empower women and adolescent girls, including the most vulnerable and disadvantaged

Indicators:

- Changes over time in national strategies and plans that **reflect increased attention to the differentiated needs** of women, newborns and adolescents, including in the four technical MHTF focal areas
- Shifts and increases in **financial allocations and expenditures** to address needs of women, newborns and adolescents, including the vulnerable and disadvantaged
- Use of disaggregated data by health information systems to track equity in access to MNH and SRHR services, in particular **EmONC and fistula care**

²⁸ UNFPA (2017). Maternal and Newborn Health Thematic Fund – phase III Business Plan, p. 18

Assumption 6.2: UNFPA advocacy and technical support to national authorities focuses on the need to increase allocation of resources, adopt favourable policies, and strengthen accountability mechanisms to ensure equitable access to quality MNH and SRHR services that meet the needs of and empower women and adolescent girls, including the most vulnerable and disadvantaged	
<ul style="list-style-type: none"> Views of national, district and community stakeholders regarding equitable access to MNH and SRHR services for women, newborns and adolescent girls, including the most vulnerable and disadvantaged Examples and results from UNFPA-supported programmes to strengthen supply and demand sides of MNH and SRHR care and empower women and adolescent girls. 	
Observations	Sources of Evidence
<p>Addressing the needs of adolescents</p> <ul style="list-style-type: none"> Roll out of the GetIN mobile App for adolescent mothers in 2 districts. A total of 1683 adolescent pregnant girls/mothers were mapped and mobilized for ANC services for the year 2018. Out of those, 846 (50 per cent) are age 15-19 years, 672 (40 per cent) are age 20-24 years and 165 (10 per cent) above 25 years. The findings also indicate that 750 had completed 4 ANC attendances and delivered; besides the number of abortions has reduced and more girls are giving birth at health facilities. This has done in the districts of Rukungiri and Bundibugyo. 137 trained Health workers engaged to identify, register and follow up young mothers for safe birth. There is continuous monitoring and end evaluation will be done First time young mother: MoH, with support from UNFPA and relevant partners, is carrying out a Landscaping exercise for adolescent health using the adapted UN tools. The priority bottleneck for adolescent health in the Promise - Renewed was to prioritize evidence-based programming, emphasizing collective action and creation of an enabling environment to ensure that interventions are guided and implemented within the five-priority strategic framework. Findings from the landscape analysis will serve as a national snapshot and will facilitate more effective planning, resource mobilization and implementation for adolescent health in the Country. It will also give an opportunity to understand adolescent policy environment, help drive the health sector to better results for Adolescents (10-19) through critical changes in programming. UNFPA is also working with two local governments to scale an innovation called GetIN application aimed at increasing access to maternal health services by pregnant adolescents through timely identification and systematic follow-up of the girls in their communities. UNFPA, with support from Korea International Cooperation Agency (KOICA), Swedish International Development Cooperation Agency (Sida) and Danish International Development Assistance (DANIDA), is implementing a ‘Live your Dream’ Campaign targeting adolescents and young people based on the fact that adolescent and young people have dreams and inspirations to act on and realize their dreams. A multi-channel approach is used to engage communities in dialogue to address factors that lead to exploitation of girls and young people and hence prevents them from attaining full potential. ‘Live your Dream’ campaign is premised on four strands namely: ‘Letting Girls to be Girls, Choosing Books before Babies, enhancing youth participation in policy advocacy and programming (‘For Youth’) and bringing generations together (Generation for Generation - G4G). 	UNFPA Uganda, 2018 MHTF Annual Report, 2018
<ul style="list-style-type: none"> GetIN Mobile is a digital mapping tool used by health and community workers to map and follow- up young pregnant girls to ensure they deliver safely at health facilities was introduced in Bundibugyo district in August 2018. Since, there has been a notable improvement in the number of pregnant women and girls seeking skilled health care at delivery. GetIN’s introduction and implementation in Bundibugyo district aimed to increase the number of girls who attend all the recommended four ANC services to ensure more safe deliveries at health facilities and improve maternal health. Two months after the 	UNFPA Uganda, News accessed from: https://uganda.unfpa.org/en/news/getin-

Assumption 6.2: UNFPA advocacy and technical support to national authorities focuses on the need to increase allocation of resources, adopt favourable policies, and strengthen accountability mechanisms to ensure equitable access to quality MNH and SRHR services that meet the needs of and empower women and adolescent girls, including the most vulnerable and disadvantaged	
<p>launch, trained midwives and Village Health Teams (VHTs) mapped more than 400 pregnant girls into the system. Today, over 770 mapped girls all followed up to ensure that they attend all the four recommended ANC visits and give birth in health facilities.</p> <ul style="list-style-type: none"> • A notable increase in the number of pregnant women seeking for maternal health services Busaru HCIV, Butama HCIII, Burondo HCII and Bubukwanga HCIII. Some of the mapped girls have also started delivering at the different health facilities with postnatal care given to them accordingly. 	<p>mobile-app-improves-maternal-health-bundibugyo-district. August 2019</p>
<ul style="list-style-type: none"> • “During the CP8, Uganda experienced an unprecedented influx of refugees, mainly from South Sudan and the Democratic Republic of Congo, much more than had been anticipated at the time of designing of the CP8. The evaluation indicated that the Uganda UNFPA CO particularly responded rapidly, effectively and efficiently to the increasing humanitarian challenge over the years; enabled by their field presence as well as strong partnership with other partners, especially government and other UN agencies.” (p.25) • All humanitarian settings have MISP implemented as per the defined package by the SPHERE project. With support from UNFPA, MISP was implemented in the nine major refugee settlements (Arua, Moyo, Yumbe, Adjumani, Kiryandongo, Rwamwanja, Kyangwali, Nakivale and Oruchinga) for the three major refugee influx emergencies from South Sudan, DR Congo and Burundi.136 As a result of the above, the affected population especially women and girls were able to access SRH information and services, adolescent SRH services, FP services, emergency reproductive health kits and dignity kits. (p. 36) • “The main challenges encountered in maternal health were inadequate funds which limited the implementation coverage; human resources issues related to recruitment; poor staff retention and staff absenteeism which affected accessibility and quality of services; stock out of commodities, supplies and equipment at service delivery points hence hindering the provision of a method mix and quality services; bureaucracy at implementing partner level delayed implementation of interventions”. (pp.36-37). • “The GoU made clear policy commitments to address GBV and the national policy set out clear mandates for government and other actors. Policies were also supplemented by a set of useful guidelines and protocols. However, there were resource and capacity constraints to implement the policies and guidelines.” (p.90) 	<p>UNFPA Uganda, GoU and UNFPA 8th Country Programme 2016-2020 Evaluation Report, 2020</p>

Assumption 6.3: UNFPA MHTF inputs are directed toward increased availability and utilization of MNH and SRHR services to women, adolescents and newborns, including the most vulnerable and disadvantaged	
Indicator:	
<ul style="list-style-type: none"> • Trends in data on MNH and SRHR service utilization, disaggregated by age, ethnicity, wealth, geography, and other available indicators.²⁹ 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • 33 per cent of girls gave birth before the age of 18 (6.6 per cent gave birth before age 15) 	<p>UNFPA Dashboard on</p>

²⁹ Given the COVID-19 pandemic, it is unlikely that data will be available for 2020; however, anecdotal information may be useful here to capture the implications of COVID-19 for maternal care.

Assumption 6.3: UNFPA MHTF inputs are directed toward increased availability and utilization of MNH and SRHR services to women, adolescents and newborns, including the most vulnerable and disadvantaged	
<ul style="list-style-type: none"> • Per cent of girls aged 15-19 who are in a marriage/union and are not currently using contraception = 86.1 per cent • Per cent of women and girls, aged 15-24, who think that wife beating can be justified ranges from 45.3 per cent in Kampala to 74.8 per cent in East Central region 	<p>adolescent and youth/Uganda, Accessed from https://www.unfpa.org/data/adolescent-youth/UG</p>
<p>Service provider perspectives on challenges to equitable access</p> <ul style="list-style-type: none"> • This is a mixed setting with refugees and host population, with language differences, it is difficult for midwives to take notes and refugees are not comfortable with people that do not speak their language. • If delivery kits not available, mothers feel embarrassed – they do not want to be naked, the delivery kit help them (cover themselves) because there is towel, kitenge. • There is very limited space and lack of equipment: Maternity/delivery room is very small; PNC is sometimes used for admissions, because there are too many clients. The oxygen cylinder is not there, and that is very crucial in managing severe asphyxia. There are no security lights, behind the maternity ward it is very dark, and the bathrooms and toilets are very dark, and the women fear going there, so just urinate outside, close to main building. During raining season, there is nowhere to stay for adolescents. • There are inadequate staff to serve a big population – the number of health workers is not enough. So sometimes the waiting hours are very long, because one health worker is attending to many clients. • The facility covers a very large geographic area – it is impossible to reach all the outreach points during the month and there is limited funding to cover all of them in a month (as per standard plan) – e.g. if you immunize a child today, and the next vaccination is the next month, and immunization schedules cannot be respected. • Traditional birth attendants are still convincing the mothers to stay at home. Currently no partner supports a strategy to engage/educate traditional birth attendants. (Note: the government discourages/prohibit the use of traditional birth attendants and thus no/few partners even integrate them within other programmes). • Also, during labour time, some mothers are still very far, and their partners are not supporting them. It would be good to promote community referrals through the use of the ambulance – because the husband will not give transport to go to the facility. But the biggest challenge is network within the facility – we have poor network connection – so sometimes they cannot reach us to call for the ambulance – that is the still the biggest challenge. • Another challenge is that some of the midwives stay outside the facility – they have to rent somewhere else – there is not enough accommodation at the health facility compound. MoH is supposed to provide housing within the health facility – so the midwife can quickly come in times of emergencies – but if she is far away, it is difficult for her to come her. E.g. if you need extra support for a complicating case – but you cannot call someone, come in the middle of the night, it is too risky. • Another challenge is the follow-up of GBV cases – at 2 weeks, 4 weeks etc. Sometimes after getting the first service, they get lost in the village, and we cannot track them. There is no support to do follow-up or home visits to check on how they are doing, because sometimes they are still stigmatised. After registering the case at the police, there is often no follow-up, maybe the perpetrator is free 	<p>Interview, Service providers, Lawmo District, May 2021</p>

Assumption 6.3: UNFPA MHTF inputs are directed toward increased availability and utilization of MNH and SRHR services to women, adolescents and newborns, including the most vulnerable and disadvantaged	
<p>again, so they think that no one is giving them justice (and it is not worth it), and sometimes they fear coming back to the health facility because of stigma. So home-based care and visits would be a better strategy</p>	
<p>Client perspectives on access to service delivery</p> <ul style="list-style-type: none"> • Transport vouchers help get to the service via ambulance by paying for fuel. Some walked to the clinic by foot (1.5 hours). • Some indicated that they were informed by friends/neighbours to go for early ANC, and they received drugs and nets to prevent malaria. VHT members hold community meetings and encourage women to go for early ANC. One woman said she did not get a net because the midwife did not have a key to the storeroom. Others complained about out-of-stock medicines. • Some women indicated they were never informed about family planning while others said they were educated during pregnancy and after birth or during her baby’s first immunization visit. • A few women noted that the midwife refused to see them because they came without their husbands. The provider indicated that for the first visit the women must come with her husband. • When asked what to improve, respondents noted that there needed to be more staff, the service providers need training on how to talk to clients without being rude, stockouts (medicines, maternity kits) need to be addressed, the facility’s hygiene and cleanliness needs to be improved. • After delivery, midwives tell women to get 40 litres from the borehole to the clinic before you can be discharged because the facility is not hooked up to water. • Women’s stories: • “I was 16 when I got pregnant. I always came for ANC here at the facility. When I came to deliver, I had complications, the baby had problems.” With the help of the ambulance, they rushed her to Kitgum government hospital. “The health workers from here, they did not go with me, but they continued to communicate with me on phone, to see how the babies was doing.” • “When I came here, they welcomed me, they did not delay me, they took me straight to the labour place, where they taught me what I should do, to get safe delivery. However, I had personal fear, since it was my first delivery. But with the midwife they rushed to help me, did not delay me.” • Whenever I come here for ANC, the midwives always take us very well, they do not delay, even if we are many, they serve all of us, and they do not delay in attending to us. The midwives from this facility are really social, they really help us and support us. They always give us advice, teach us, always encourage us not to fear during the time for delivery.” 	<p>Group discussions with women and girls, Lawmo District, Uganda, May 2021</p>
<ul style="list-style-type: none"> • UNFPA in liaison with MoH commissioned a study in 2018 to identify these groups and the metaphor of an “onion-peeling” helped to unravel the layers of hard-to-reach as they emerge from the broad categories of hard-to-reach groups: <ul style="list-style-type: none"> ○ Hard-to-reach are forgotten by omission, stereotyping, exploitation or due to geographical location, policy and other structural factors. ○ Harder-to-reach can be categorized as those individuals who, for some reasons, are disengaged by marginalization. These groups lack an active voice and place in society. Examples include mountain communities, and nomadic/pastoralist communities (Karamoja region and other districts in the cattle corridor). They may be difficult to reach but not disengaged or hard to hear. ○ The hardest-to-reach often identify with the marginalized groups, but due to their intersecting identities, they may experience further marginalization and isolation. Limitations on these individuals may be imposed by existing national policies and laws, 	<p>UNFPA Uganda, GoU and UNFPA 8th Country Programme 2016-2020 Evaluation Report, 2020</p>

Assumption 6.3: UNFPA MHTF inputs are directed toward increased availability and utilization of MNH and SRHR services to women, adolescents and newborns, including the most vulnerable and disadvantaged

Examples of people in this category include drug users, individuals with different sexual orientation, girls subjected to FGM whose families keep them from public view to avoid legal consequences.

- The evaluation recommended that, in order to strengthen equity, the human rights-based approach and leaving no one behind, the next CP should actively advocate for use of the differentiated service delivery model to facilitate effective response to the peculiarities of needs and diverse contexts of hard-to-reach populations and communities. Service delivery and programming models for the general population are generally not effective for reaching hard to reach communities such as nomads, people with different types of disabilities, fishing communities, people leaving in mountainous areas, most-at-risk populations and the LGBTI. There are lessons learnt from HIV/AIDS programming that could be adapted for use to meet the need for these groups.

Area of Investigation 7: Catalytic role

Evaluation Question 7: To what extent has the MHTF fulfilled its catalytic role enabling UNFPA to ‘punch above its weight’ in support of MNH outcomes and integration with SRHR?

Sub-questions:

- To what extent has UNFPA used the MHTF as a vehicle to **play a broker role for the promotion of MNH** and wellbeing in high MMR countries, improving coordination and partnerships, leveraging more funding from both international and national sources, and providing effective strategic direction, technical assistance, and capacity building through country-driven interventions?
- To what extent has the MHTF leverages a range of **discernible, tangible, and practical results**, including political commitments and policy support and financial commitments and investments
- To what extent has global and regional technical support from UNFPA supported country teams and national health authorities through strengthening reliable data and information collected through monitoring and review, stimulating knowledge sharing approaches, and **identifying, scaling-up or replicating innovation** and good practices within and between countries?

Evaluation Criteria	<i>Relevance, efficiency, coordination</i>
Rationale	Catalytic is defined as an agent that provokes or speeds significant action. In this evaluation, catalytic actions are those that are assessed to provoke or accelerate relevant change or progress. A catalytic role is therefore one that identifies, promotes and advances those actions. There is an implied counterfactual which is that without the catalytic investment, significant change would not have occurred or would have occurred only very slowly. Given its wide scope, its relatively low resource envelope, its commitment to sustainability, equity, human rights and gender equality, the MHTF gains more traction and achieves better results if it concentrates its effort on catalytic investments and actions, playing a broker role within UNFPA and with external partners, and sparking political, programmatic and financing commitment beyond its own investments. Catalytic support includes using the UNFPA mandate to good effect, focusing on its role to strengthen partnerships, coordination, strategy and capacity building, and extending innovation through knowledge management strategies including the identification of best practices.

Assumption 7.1: The MHTF is an effective vehicle to play a broker role both internally within UNFPA and externally with programme countries and other partners at global, regional, and national levels for the promotion of MNH in high MMR countries through its comparative advantage to coordinate, build partnerships, leverage funding	
Indicators:	
<ul style="list-style-type: none"> • MHTF engagement in or support to strategy, policy and planning development especially involving other partners and players to forge partnerships and negotiate coordinated approaches and strategies including the allocation of roles and responsibilities • Examples of UNFPA convening partners to assist with the development of costed maternal health approaches and strategies including national plans • Examples of UNFPA leadership or coordinated working with other country level partners to provide effective strategic direction, technical assistance, and capacity building through country-driven interventions • Examples of MHTF support to UNFPA intervention to bring partners together around plans, ideas, proposals, strategies in ways they otherwise would not have and to allocate additional resources, focus, effort to these • Specific examples of how MHTF at global level or through support to UNFPA CO efforts at country level helped negotiate the involvement of new partners, increased resources, better approaches, or innovations to support/ fund MNH at any level (global, regional or country) • Clear definition of the role and approach of UNFPA to working with SDG3 GAP agencies at country level especially on MNR related activities and plans. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • Coordination occurs with UNFPA through the donor group for SRHR TWG, which meets quarterly, although recently it has moved to monthly. The focus since the beginning of the year is to see how to expedite the process of the different SRHR related policies that have stalled over for the last few years. The group developed talking points to share with its leadership (heads of agencies) for use in advocating with very high-level senior people in government. • There was close coordination with UNFPA during the COVID-19 response. • There was good coordination with UNFPA when we had fistula funding. • Regarding technical leadership, “We share is what is it that we can do, and what is it that UNFPA can do. Our counterpart at UNFPA is trying to ensure that UNFPA goes to partners who are qualified and have strong capacity to implement those things – instead of traditionally always going through though the MoH as main IP – which helps them do a bit more implementation out in the field.” UNFPA works more and more through IPs on the ground, they give the IPs the funds, but working with and through the DHOs – which helps them speed up the implementation (because channelling funds through MoH to the districts is very slow). <p>Biggest contributions from UNFPA:</p> <ul style="list-style-type: none"> • Policy development and contribution to guidelines, updating documents, bringing in short-term consultants to work on that. That work was done almost 2 years ago. With quality-of-care work at national level, UNFPA has also contributed to the Quality-of-Care tools and indicators, they contribute to the design for that, as part of the Q of Care working group – and MCH cluster. In terms of developing tools and guidelines, that is where I can see their advantage coming through for EMONC. • At the MCH cluster – this is where we get reports from the various TWG, e.g., FP TWG (update on high strategic issues that have been discussed), e.g., UNFPA played a critical role in hiring consultants to draft the FPCIP 2021-2025, giving feedback and high-level advice on policies and areas that need support. 	Interview, Development partner, Kampala, May 2021

Assumption 7.1: The MHTF is an effective vehicle to play a broker role both internally within UNFPA and externally with programme countries and other partners at global, regional, and national levels for the promotion of MNH in high MMR countries through its comparative advantage to coordinate, build partnerships, leverage funding	
<ul style="list-style-type: none"> Also, (UNFPA contributed to) developing framework for MPDSR, updating tools for that. Otherwise, they (UNFPA) come and contribute with their technical expertise, looking at some of the issues coming through, but in terms of following up on actions, e.g., PPH which is a huge issue, recently we went ahead with the stakeholders to provide a concept note or framework for revamping the PPH guidelines – technical input/feedback. 	
<ul style="list-style-type: none"> The TWGs are good platforms to share a bit of information – but more deliberate and intentional actions are needed to reach out and coordinate with particular partners, if another partner is doing something similar. UNFPA needs to be very deliberate to reach out to those other partners to reach out - what are the potential overlaps, synergies. How well they do that, it is very difficult to know. Therefore, health development partners/donors who fund UNFPA for similar activities, need to call for a joint meeting with partners engaged in similar activities to ensure coordination. 	Interview, Bilateral partner, Kampala, May 2021
<ul style="list-style-type: none"> MHTF funding for the compilation of the annual MPDSR has been instrumental in advocating and raising awareness about key gaps and issues at national referral hospitals and the level below (referring facilities). The evidence generated through the annual report, and UNFPA advocacy, gained attention of the MoH senior management who established weekly meetings to discuss gaps/issues and implement/monitor recommendations and action points. MHTF support to the annual MPDSR report is considered catalytic for high level MoH support and action. “MHTF supports the compilation, analysis and writing of the national MPDSR report every year. That report has been a catalyst to MoH was able to strengthen its leadership and focus on MPDSR. Out of that report, the data shows that most of the maternal deaths are coming from the highly populated districts, and the MoH top management, was able to focus on the national referral hospital – KAWEMPE – just to see what are the issues that cause the maternal deaths there. From having those regular MPDSR meetings every Monday, which involved the Permanent Secretary, the director general of health services, the Director of Curative Services, the Commissioner of Nursing and Midwifery, the Directorate of Health Services of KCCA, partners like UNFPA, UNICEF and USAID. The weekly meeting was also able to attract private players like Stanbic Bank – they supported the platform.” UNFPA, with Sida funds (not MHTF) funded “specialist teams” to go from national referral hospitals to the referring hospitals, to give them technical support to solve the issues. UNFPA uses Netherland (ANSWER) and Sida (Joint GBV programme) funds to support the district level MPDSR committee meetings. Support to the Fistula TWG as served as a resource mobilization platform whereby the MoH expresses its needs and gaps and different partners who participate offer financial/technical support to fill those gaps After noting that postpartum bleeding/haemorrhage was the biggest cause of death, this year, the “post-partum haemorrhage activity framework” was developed to intervene and try to address the issue and solve the biggest issue of maternal deaths tin the country. 	Interview, UNFPA Uganda staff, May 2021
<ul style="list-style-type: none"> The implementation modality of GoU/UNFPA country programme is a key to success, as is the presence of UNFPA staff within districts. This enhances the visibility of UNFPA and improved coordination. Strategic engagement with the MoH at senior level produces quick results. 	UNFPA Uganda, GOU/UNFPA 8th Country

Assumption 7.1: The MHTF is an effective vehicle to play a broker role both internally within UNFPA and externally with programme countries and other partners at global, regional, and national levels for the promotion of MNH in high MMR countries through its comparative advantage to coordinate, build partnerships, leverage funding	
<ul style="list-style-type: none"> • Coordination at the national level was highly commended, in particular its full support for the full functionality of SRH/HIV coordination platforms at MoH. UNFPA guidance and leadership also supported the functionality of the inter-agency GBV coordination body and National GBV reference group. • Presence of UNFPA staff in decentralized offices in Karamoja and Eastern regions, Gulu Municipality (Acholi sub-Region and West Nile region) was appreciated and improved the communications between the district government and UNFPA. (However, technical staff in those areas were overstretched in covering wide geographical areas.) 	Programme Evaluation Report, 2020
<ul style="list-style-type: none"> • MHTF support for the development of the GIS system was catalytic, as Sida picked it up and funded UNFPA to support its expansion to further districts. • MHTF funds and advocacy for the compilation of the annual MPDSR report has been catalytic since it gained the interest and support of the MoH, attracted other donors/partners, and Sida funded UNFPA to operationalise MPDSR at the district level. • The catalytic fund was able to establish the need to do the social integration of those survivors – and make it a national priority – instead of only a small project. The Clinical Services Department is now taking more leadership – even collaborating with Gender Ministry. UNFPA advocated for this through the revision of national strategy – highlighting it – so that MoH became interested. 	Interview, MoH Uganda, Kampala, May 2021
<ul style="list-style-type: none"> • Considering the limited amount of funds under MHTF, the key strategic question for the CO is how to position UNFPA in the future when there are other players with big money. It will depend on how we use catalytic support and how to do well without money to influence discussions and resource mobilization. At the global level, there should be a prioritization on the generation of evidence as that will help to influence others to act and to provide funds. • UNFPA has capacity to work with the young person – “so we should position ourselves that all we focus on the young person – and when investing in the young person – we improve maternal health, help the government, appreciate maternal health – always though the angle of the young person, the investment of the young person. We also have special advantage in the integration of services.” • UNFPA contributes significantly to the TWGs, including the RMNCAH investment case and those broader, larger policies as well as the smaller, technical policies. • Secondment to the government makes a difference; “when we are thin on secondments, we lose out a lot on the politics.” 	Interview, UNFPA Uganda staff, Kampala, May 2021
<ul style="list-style-type: none"> • UNFPA is acknowledged as MH leader within UN in Uganda – “we pick (work) on all the pieces generally, that have to do with MH.” But specifically, for the MHTF – on midwife programming, fistula programming, programming on MPDSR – for those three strands, UNFPA takes the lead generally, in health sector, and at MoH, and within the UN. MHTF funding allows UNFPA to work on upstream level – policy and strategy. At present this work is focused on the Revised RMNCAH Sharped Plan (i.e. the new GFF investment case). The small funding also allows UNFPA to support service delivery HSS – like midwifery and fistula – training/capacity development, with a focus on sustainable investments for the country, rather than as a project mode. 	Interview, UNFPA Uganda staff, Kampala, May 2021

Assumption 7.1: The MHTF is an effective vehicle to play a broker role both internally within UNFPA and externally with programme countries and other partners at global, regional, and national levels for the promotion of MNH in high MMR countries through its comparative advantage to coordinate, build partnerships, leverage funding	
<ul style="list-style-type: none"> • UNFPA main contribution is the leadership on midwives – contributing towards ensuring that midwives in the countries are increased in numbers. • UNFPA should take a more strategic approach in terms of working with health facilities to improve with the quality of services. Taking a step-by-step approach in working with facilities. Even UNFPA approach in improving quality of services, it was more “business as usual”- they just trained a few health workers here and there, but it is not structured. 	Interview, Bilateral partner, Kampala, May 2021
Assumption 7.2: The MHTF leverages a range of <u>discernible, tangible, and practical results</u>, including political commitments and policy support, and financial commitments and investments	
Indicators:	
<ul style="list-style-type: none"> • Documented and reported progress on policy processes and political commitment in partner countries • Examples of increased financial commitment from other donor partners for SRHR-MNH efforts in partner countries linked to MHTF advocacy and investments • Examples of trends in financial commitments in countries to MNH • Examples of UNFPA technical or programmatic support to country teams and national and sub-national health authorities that were taken forward by other partners • Assessed technical quality of UNFPA assistance as reported by health authorities and partners • Relevance of UNFPA technical assistance as reported by health authorities, practitioners and implementing partners • Examples of UNFPA engagement in capacity building, which is sustained, relevant and meaningful in monitoring, research, review and knowledge management • Examples of UNFPA at country level building momentum and supporting tangible policy and programming changes. 	
Observations	Sources of Evidence
MHTF as catalytic for resource mobilization <ul style="list-style-type: none"> • There is a clear link between the MHTF funded activities (see other documents and interview notes) and the Sida-funded MNH activities, which is an indication that MHTF investments in the four technical areas had catalytic effects, in terms of mobilising additional funds and being integrated into this new Sida-funded GBV programme, for example: <ul style="list-style-type: none"> • Sponsorship for education of midwives and bonding to hard-to-reach districts • Scaling up of the GIS system for registration and licencing of midwives – Sida-funded an expansion to additional 15 districts. • Procurement of MNH kits for health facilities. 	Interview, Bilateral donor, Kampala, May 2021
<ul style="list-style-type: none"> • UNFPA mobilized more resources from Sida under the UN Joint Programme on GBV and the EU-Spotlight initiative to support 18 Fistula repair camps by 14 Hospitals and social reintegration. 	UNFPA Uganda, Final Annual Report for MHTF, 2020.
MHTF as catalyst for programming <ul style="list-style-type: none"> • UNFPA supported the GIS to monitor and track midwives and their distribution in country. “We use it to support the distribution of midwives. We are still in the roll-out stages and have reached 30 districts. Sida has come on board to 	Interview, MoH National staff, May 2021

Assumption 7.2: The MHTF leverages a range of <u>discernible, tangible, and practical results</u>, including political commitments and policy support, and financial commitments and investments	
<p>facilitate and further scale-up. MHTF is catalytic: the platform was created, and then we used it to mobilize funds from other donors.” MHTF used to fund a dedicated UNFPA staff to support the midwifery department of MoH in the past; now, UNFPA supports capacity development of MoH staff working in the department.</p> <p>Other examples of catalytic funding:</p> <ul style="list-style-type: none"> • MHTF funding for fistula social reintegration: EU Spotlight (GBV programme) and Sida-funded Joint GBV Programme with UN Women includes fistula activities. • MPDSR: MHTF funds and advocacy for the implementing the annual MPDSR report has sparked support and commitment from the MoH and has attracted other donors/partners, including through Sida-funded UNFPA activities to operationalise MPDSR at the district level. UNFPA and WHO have played a role in advocating for the MPDSR process and making the evidence about the root causes of maternal and neonatal deaths available. MPDSR is now led by the senior management of the MoH. UNICEF and USAID came on board with technical and financial support later on (although it is not clear exactly what year). Sida is funding UNFPA to strengthen district MPDSR committees. • As a result of the weekly MPDSR meetings, a national PPH Action Framework was developed to address the weak blood supply chain system. UNFPA is supporting the revision of the list of life-saving drugs, i.e. shifting from oxytocin (which requires a cold chain) as first line drug to other heat stable drugs. 	
<ul style="list-style-type: none"> • “When you look at Adolescent Health, you see a unique perspective or approach, of carrying out “outreaches” – we have an issue of access in this country, so the catalytic funding of UNFPA helps us get those services to the adolescents, refugees and hosting populations, to the most vulnerable. The health facilities are not able to do outreaches, so the UNFPA funds have helped us do that.” 	Interview, MoH staff, Kampala, May 2021

Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries
<p>Indicators:</p> <ul style="list-style-type: none"> • Documented and reported progress by UNFPA in developing and implementing a knowledge sharing strategy and approach that was systematically disseminated at global and regional levels • Examples of regional level knowledge sharing, identification of innovations and good practices • Examples of UNFPA approaches to gathering evidence about best practices and developing ideas and strategies to take these to new countries or settings • Examples of UNFPA support to better monitoring and review and to more knowledge sharing among country teams and national and sub-national health authorities • Reported timeliness of UNFPA technical assistance • Assessed technical quality of UNFPA assistance as reported by health authorities and partners • Relevance of UNFPA technical assistance as reported by health authorities, practitioners and implementing partners • Examples of UNFPA engagement in capacity building, which is sustained, relevant and meaningful in monitoring, research, review and knowledge management

Assumption 7.3: Global and regional technical support from UNFPA fostered, identified, and scaled-up innovation and good practices within and between countries	
<ul style="list-style-type: none"> • Examples of UNFPA at global and regional level building momentum and supporting sustained roll out of innovation or best practices • Examples of knowledge development, management, and communication especially around good practices in the MHTF programme. 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> • Refer to Assumptions 1-4 for examples of technical assistance, capacity building and knowledge exchange/best practices. 	

Area of Investigation 8: MHTF governance and management	
Evaluation Question 8: To what extent have the MHTF management mechanisms and internal coordination processes contributed to the overall performance of the programme? Specifically, how have these facilitated: (i) resource mobilization for the MHTF; (ii) the breaking of silos among UNFPA programmes; (iii) the integration of MNH within country programmes; and (iv) effective oversight and guidance by the MHTF Advisory Committee?	
Sub-questions:	
<p>a) To what extent has the MHTF management mechanisms and internal coordination processes contributed to the overall performance of the programme including through influencing the overall strategic directions and efforts of UNFPA in MNH and broader SRHR more broadly?</p> <p>b) To what extent have MHTF management mechanisms and internal coordination processes benefitted from effective oversight and guidance by the MHTF Advisory Committee and contributed to MHTF resource mobilization?</p> <p>c) To what extent have MHTF management mechanisms and internal coordination processes contributed to breaking silos among UNFPA programmes at global and national levels including strengthening integration of MNH within country programmes?</p>	
Evaluation Criteria	<i>Effectiveness, efficiency, coordination</i>
Rationale	The MHTF is one of several thematic funds in UNFPA. Focused on maternal health, it is also one of the few global maternal health funds (others include the GFF) but is distinguished in part by its specific focus on four technical areas (midwifery, EmONC, MPDSR and fistula) in 32 countries. Resources are generally declining as global MNH is less prioritised in the SDGs. Coordination, management, leadership, and efficiency are critical in order to ensure the aims of the fund are met and maximum impact from available resources is realised.

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver
Indicators:
<ul style="list-style-type: none"> • MHTF programme guidance which incorporates required adjustments/improvements in SRHR policies and programmes communicated to other branches • MHTF staff/secretariat participation in forums and meetings at global, regional and CO to develop broader SRHR policies and to integrate services • MHTF results frameworks and programme reports incorporate linkages to SRHR policies and programmes • UNFPA staff in other branches engaged in SRHR report MHTF input and influence on policies and programmes • Minutes and report of intra-UNFPA coordinating bodies note cross influence of MHTF and SRHR on policies and programmes • Examples of mechanisms to support coordination, strategic direction, forward momentum, and overall performance at global, regional and country levels • MHTF investments and activities contributed to strengthening coordination with other UNFPA thematic programmes

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver	
<ul style="list-style-type: none"> Country offices approached thematic areas holistically, in line with countries' own systems (integration at the country level) Examples of efforts to integrate across the SRMNCAH agenda at global, regional and country level MHTF support enabled increasingly effective performance of the programme, breaking down barriers to programmatic silos and supporting increased efficiency Examples of the MHTF role and activities in relation to regional knowledge and management approaches 	
Observations	Sources of Evidence
<ul style="list-style-type: none"> The collaboration and coordination between the UNFPA CO, GoU and other cooperating partners is important and is aided by the implementation modality of the GoU/UNFPA and the presence of UNFPA staff within districts. Operating decentralized field offices was considered by stakeholders as a key strategy for fostering visibility, technical assistance and enhancing the functions of coordination, sub- national level partnerships and quality assurance. An area of improvement is to expand coverage in relation to the number of district and ensure that staffing is adequate. UNFPA has a solid financial management and tracking system to facilitate programmatic and financial accountability. However, there are delays requisition of funds by IPs and disbursement by UNFPA, affecting the timely and quality of implementation activities. There need to be accountability mechanisms integrating multisector programming and for integrating gender equality, rights and gender transformative programming within existing GoU programmes. For example, the CO should engage the MoH for the strengthening the MPDSR committees at district level, including the strengthening of community level intelligence/surveillance for maternal deaths; for encouraging pregnancy mapping and tracking by VHTs; and for strengthening the accountability/feedback systems for health at community and national level. 	UNFPA Uganda, GOU/UNFPA 8th Country Programme Evaluation Report, 2020
Development partner perspectives	
<ul style="list-style-type: none"> The role of UNFPA as a convening power is appreciated, along with its ability to gather multiple stakeholders from government, NGO/CSOs, donors, academia and private institutions to participate in a national conference focusing on the integration of SRHR, GBV and HIV in February 2021. 	Interview, Bilateral donor, Kampala. May 2021
<ul style="list-style-type: none"> The national level TWGs work well, e.g., the SRHR TWG but also MPDSR, but there is a need to strengthen coordination at SHO level. "But EMONC and midwifery, it is not clear – we recognize they do not have so much funding – but the activities still do not come across clearly. The collaboration is left at the Maternal Child Health Cluster TWG under the MoH national even – we share date etc., but we do not specifically know how UNFPA is touching on EMONC and midwifery. But it is not clear what UNFPA is doing in this. Midwifery as a technical area – we do not discuss that – I do not even know what is under midwifery – I know we discuss at the celebration of the national day – so it is not clear what the work is under midwifery – the regulation etc. Maybe that is discussed in other platforms – not for the MCH cluster. But EMONC should be discussed at this MCH cluster. We do not really talk about EMONC at the MHC – we talk about the different sub-areas. When we discuss the EMONC issues, two years ago, UNFPA was very involved in the updating of the guidelines, with WHO and other stakeholders – now we just discuss issues under the EMONC – and there is no link, unclear what UNFPA is doing at the district level." 	Interview, Development partner, Kampala, May 2021

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver	
<ul style="list-style-type: none"> • Having UNFPA funds go through MoH level and then down to the local level – it was very different for partners, because it was very difficult to bring the DHO to the table. One of the biggest challenges we had with UNFPA giving resources through MoH and then to the districts – there was little transparency. • The support to district level coordination is an area to focus on –coordination at the global level is going well but does not translate down to DHO led coordination yet. 	
<ul style="list-style-type: none"> • A challenge is the UNFPA “business as usual” where strategic thinking is not happening within the team. The problem is that UNFPA is used to “swinging off their technical mandate”, and technical partnership with government, and they go more into implementation/operation mode, but they need to balance implementation with strategy as they remain a very strong partner who can influence the MoH. UNFPA gets so much into their implementation mode, instead of maintaining their role as technical advisors and technical partner of MoH. Striking a balance is very important, what is the value addition of UNFPA as compared to CSO. As more donors start to fund them bilaterally, they get swamped into implementing projects, meet donor requirements etc. instead of keep focusing on what they really need to do at the national level. • Another observation, which has been discussed with CO management, is that within UNFPA internally, the different technical expertise, is not being pulled together. “When you go to the field level, you do not see the interconnectedness between components, integration between the components, because they are quite siloed, to really implement a comprehensive system strengthening support. If I look at health facility level, where we support GBV, FP, MNCH etc. – you would expect the team to sit down together, to see how they can work together, support the full package – liking data management commodities etc.” • The many different IPs that implement components of the project do not coordinate well together. “There is not an appreciation of the integration we are talking about. Having different IPs is not the problem, because having a partner that can cover all areas is not easy, but the UNFPA field coordinator must be strong, to ensure very strong integration. If the team internally at UNFPA is not able to do this, then everything falls apart. This appreciation needs to come from UNFPA internally. The good news is UNFPA has responded to this feedback, and we have received a new strategy which we are reviewing. They have looked critically on how integration within the programme and organisation can be improved. But at least, it has started a reflection process within UNFPA on how to improve some of these issues.” • UNFPA manages through a very “output based management process, we implement XX activity – but do not think about strategy and how the components fit with each other.” They do output-based partnership management. 	Interview, Bilateral donor, Kampala, May 2021
<p>Government partner perspectives</p> <ul style="list-style-type: none"> • “What makes UNFPA unique is that they have tried to support many levels of what I call the comprehensive package of care – UNFPA is involved in supporting policy and guidelines development, they support dissemination – and they have operational support to the districts, either through CHOs or CSOs, they get money to the districts through them. They also are one of the leading partners in Maternal, Newborn and Child Health – and support the MoH across the continuum of care.” 	Interview, MoH official, Kampala, May 2021
<ul style="list-style-type: none"> • Challenges with implementation and support include delayed transfer of funds and direct funding of schools without adequate notification to the MoES to enable them to monitor and provide support. While the district selects the midwifery 	Interview, MoES official. Kampala. May 2021.

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver	
<p>candidates, the MoES should be informed about the process for monitoring purposes. “Some things remain at national level, e.g., for diploma students, there is another process. For them, we use joint admission board; that process is managed at the national level.”</p> <ul style="list-style-type: none"> • There is an inter-ministerial meeting between MoH and MoES to coordinate health education and training. It would be good to have the UNFPA consultant midwife participate because it is a strategic-level meeting that covers issues of human resources, budgeting, collaboration, and clinical attachment, internships, etc.” She is currently not participating in those meetings, but she should.” 	
<p>Regarding coordination, with other UN agencies:</p> <ul style="list-style-type: none"> • UNICEF: There is strong coordination between UNICEF and UNFPA in terms of coordinating activities and avoiding overlap in MNH support in the West Nile and Acholi sub-regions where both are active. Since UNFPA received funds from Netherland for the ANSWER programme late 2020 (which includes significant funds for MNH), the need to coordinate activities in those sub-regions have become important. Since beginning of 2021, UNICEF and UNFPA meets quarterly to coordinate activities at the national level and want to extend these coordination meetings to the sub-regional level. When they have funding for the same type of activities (e.g. EMONC support), they make sure they do not provide the same kind of support in the same health facilities, but rather “divide the facilities/communities up geographically” between them. For example, for MPDSR, UNICEF, UNFPA and WHO collaborates to support the districts MPDSR committees – each organization covers a different sub-region/geographical area, so they do not overlap. • WHO: is responsible for guidelines; therefore, there is a lot of coordination with WHO at the national level through various TWG, i.e., maternal and child health, and also adolescent health. At the operational level, UNICEF, UNFPA and WHO collaborate in the district of Hoima for MPDSR. to see how to improve MPDSR in that region covering 3 districts: UNICEF supports Arua in West Nile and UNFPA covers Hoima (humanitarian setting) and neighbouring districts. Because Hoima regional referral hospital oversees all other districts in terms of standards and technical capacity, they can support other districts in those areas. 	<p>Interview, MoH national staff, Kampala, May 2021</p>
<p>UNFPA comparative advantage</p> <ul style="list-style-type: none"> • Regarding the relative comparative advantage of UNFPA in Uganda, “I think we really stand out in midwifery because I do not see any other agency that can talk about midwifery the way UNFPA can. We also stand out in MPDSR, and fistula and we give credit to MHTF to enable us to contribute in that.” • There is a comparative advantage working both at policy and service level and making sure there are strong linkages between the two levels. 	<p>Interview, UNFPA Uganda national staff, Kampala, May 2021</p>
<p>There are three key advantages that UNFPA has:</p> <ol style="list-style-type: none"> 1. The UNFPA integration approach – linking MNCH with FP and GBV. UNFPA has made good progress with integration – it is a steady progress. 2. The Field Support Unit at the country office level, and field presence (through the 7 field offices ensures a strong anchoring of UNFPA at the district level. That is the biggest advantage regarding UNFPA here in Uganda. 3. UNFPA ability to implement SRHR in humanitarian settings. It is 95 per cent part of the refugee response. 	<p>Interview, UNFPA Uganda national staff, Kampala, May 2021</p>

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver	
<p>UNFPA Coordination with other UN agencies</p> <ul style="list-style-type: none"> • UNFPA has not used the catalytic fund to sit down with UNICEF and WHO to have joint coordinated support to the MoH, as is supposed to be done under the new UN framework, where you have leads that are corresponding to the implementation of the implementation of the framework. That is the new way of working. “Maternal health is one of the easiest for UNICEF, WHO and UNFPA senior management teams to sit down to discuss and coordinate. But we have not done that here at the country level. I would go as far as to say we “missed funding” because we were not up to that level of coordination... how to be complementary between UNFPA, UNICEF, and WHO.” • “We have not done enough in fistula; it has been piecemeal. We have not done enough fistula repairs for at least two years – perhaps it was due to USAID stepping out. But I would have imagined that among the HDP donors someone would pick it up.” • On coordination of refugee/humanitarian response – and government stewardship: The leadership and accountability of the government – it needs to be strengthened and supported. It is a national excuse: That the refugee influx in itself is a huge pressure on the health system. The political agenda that was hacked. There is a need to push the government to ensure stewardship. The MoH must be at the centre. Although there are structures area already in place –more resources go through strengthening them. 	<p>Interview, UNFPA Uganda national staff, Kampala, May 2021</p>
<p>Opportunities/challenges with MHTF as a mechanism</p> <ul style="list-style-type: none"> • MHTF has “pre-determined” interventions – if you want to introduce a new intervention, you have to drop one of the pre-determined interventions; but they are also important, and it is difficult for us to drop one of them. There is a lack of flexibility. • “The MHTF funds are very limited, so hard to drop one intervention. The funds are limited, the expectations are high, and the problem which we are trying to address is so huge and complex.” • The challenge is that follow-up activities are often needed to ensure that activities supported by MHTF are implemented effectively and this is not always possible with small amounts of catalytic funding. • Midwife should/will be at the centre of achieving our goals for maternal health. The support to midwifery in terms of regulation, association etc. – UNFPA is unique in that area; not many partners are supporting midwifery. • MHTF raised the profile of the four technical areas. Now you see many programmes and developing partners, supporting these areas, so it has been really catalytic. That has been the main achievement of MHTF. It contributes to the overall strategy, because the global strategy is ending preventable maternal deaths and comorbidities e.g. fistula. So, it aligns every well with global and country level... the new 9th country programme focuses on ending preventable deaths. To reduce maternal mortality rates, there must be access to EMONC care services. There has to be demand – that is the second output. Women and girls must be empowered to demand and use those services. That is very critical. UNFPA is investing a lot in leadership and governance, at all levels, from national to facility and community. It is cross-cutting, for this to happen, there must be an enabling policy and legal environment, and also HSS is cross-cutting because it affects service delivery. • “However, if we could add something, the MHTF should add a community component. MPDSR links with communities, but other 3 areas are supply/facility based. Most of our communities are rural – and you really need to build community 	<p>Group discussion, UNFPA Uganda national staff, Kampala, May 2021</p>

Assumption 8.1: MHTF management mechanisms and internal processes within the MHTF and with other UNFPA departments <u>fostered effective and efficient coordination of programmes and prioritization of financial and human resources to deliver</u>	
<p>structures and systems – and link them to health facilities. Community systems for accountability etc. If you only focus on supply/facility level, and if you do not work on community level, you will not succeed. E.g. when you look at the first delay (decision), and second (referral) – they contribute to 80 per cent of deaths. The THIRD delay only about 20 per cent. So, the MHTF should add a stronger community component, including an accountability mechanism which provides feedback, i.e. MPDSR must provide a loop-feedback to the quality of services- so what happened, does not happen again – if feedback mechanism is not working, MPDSR is not useful.”</p>	
Assumption 8.2: The MHTF management mechanisms and internal coordination processes benefitted from <u>effective oversight and guidance by the MHTF Advisory Committee and UNFPA leadership, and contributed to MHTF resource mobilization</u>	
Indicators: <ul style="list-style-type: none"> • Advisory Committee role is clearly identified through terms of reference and performance standard • Meetings and other engagement enabled the Advisory Committee to meet its terms of reference • Materials distributed in the form of briefing and information sharing were sufficient to ensure the Advisory Committee could provide strategic guidance and oversight • Guidance of the Advisory Committee was considered and incorporated into the MHTF approach and rollout efforts • Trends in resources mobilized and constraints identified • Advisory Committee contributed to resource mobilisation strategy • Examples of resource mobilisation efforts and results • Examples of inter-relatedness of funding modalities within MHTF and between MHTF and other funding streams in UNFPA including core funds. 	
Observations	Sources of Evidence

Assumption 8.2: The MHTF management mechanisms and internal coordination processes benefitted from <u>effective oversight and guidance by the MHTF Advisory Committee and UNFPA leadership, and contributed to MHTF resource mobilization</u>	
<ul style="list-style-type: none"> • MHTF supports “pre-determined” interventions – “if you want to introduce a new intervention, you have to drop one of the pre-determined interventions, but they are also important, so difficult for us to drop one of them.” The MHTF funds are very limited, so hard to drop one intervention. The funds are limited, the expectations are high, and the problem which we are trying to address is so huge and complex.” • The lack of flexibility in planning of MHTF is key – perhaps there is a need to focus more on catalytic effects to gain more. The challenge is that we often need follow-up activities – there is no more additional activities, then you have to drop another activity. It was programmed for 5 years, from 2018-2022. Those activities are already there, so if we want to add another activity, it has to be added within the existing work plan/budget. • MHTF has predetermined activities/indicators – so if there is a new activity/approach, it might not be supported. “This is a particular MHTF challenge – the work plan issue, we indicated this as an issue at the global MTHF fund a couple of weeks ago.” • “We have the opportunity to have new donors/funding sources. We should use MHTF to fund catalytic activities – to have other donors take on and scale-up.” <ul style="list-style-type: none"> ○ “What we can do differently” – I think it is bringing the demand/community component into the MHTF, i.e., demand creation for fistula repair at community level, midwifery at community level. ○ Midwife should/will be at the centre of achieving our goals for maternal health. The support to midwifery in terms of regulation, association etc. – we are unique in that area, not many partners are supporting midwifery. ○ We also have a demographic dividend (DD) approach – we make sure that the DHOs and partners understand our entry point is the adolescent girl – the teenage girl and the DD should be an entry point for maternal health and SRHR services. Also relate it to “keeping the girl in school” and “empowerment of the girl”. Putting the adolescent at the centre is a key strength of UNFPA.” 	<p>Group discussion, UNFPA Uganda national staff, Kampala, May 2021</p>
<ul style="list-style-type: none"> • At the organization level (internal): UNFPA CO has been restructured internally to facilitate the integration of different programmes, foster collaboration across technical teams, ultimately to support the delivery of the “integrated package of SRHR rights: Integrated SRHR, Integrated Field Services, and Gender (GEWE) team. The CO recently developed an internal “integration tool” to facilitate/accelerate integration in the implementation of the 9th country programme which was launched this year. • Integration challenges: Shifting the mind-set and working culture internally remains the key challenge. There is still a need to “remind” colleagues to look for opportunities for integration which would result in more efficiency and value for money. The guidance/push from HQ on integration is unclear/could be strengthened, i.e. as long as it is unclear at global level – it will also be so at country level. • As there is no specific major maternal health (other than MHTF), it remains integrated “in pieces” in other larger, bilateral programmes. • Beginning of the 9th country programme, UNFPA developed an “integration checklist” to highlight the different entry points. It is both a tool for internal team collaboration – and also for the IPs to use. It could also be a reporting template for IPs that reports on integrated service delivery, but this needs to be communicated as an expectation for the 9th country programme in terms of integrated programming and service delivery. 	<p>Interview, UNFPA Uganda national staff, Kampala, May 2021</p>

Assumption 8.2: The MHTF management mechanisms and internal coordination processes benefitted from effective oversight and guidance by the MHTF Advisory Committee and UNFPA leadership, and contributed to MHTF resource mobilization

- No global tool was available – so this was started at country level in response to the priorities of the 9th country programme.
- UNFPA (HQ) programmes are enormous, it becomes difficult to see how you should bring other topics/aspects on board. So, this tool we are developing will help us (at the UNFPA CO).
- Last year, HQ asked what is being done at country level with cervical cancer. Previously, when this was raised by CO, it was told not to spread too thin. But since there was an IP who already did STI screening, PAC etc. the CO wrote a small story which HQ used to present at a global meeting. **“We do not always need extra money; we need to shift our thinking.”**
- With regard to TA from HQ, the CO noted guidance from the HIV advisor regarding integration. **Main support comes from ESARO through the 2gether4 SRHR platform.** Those are the main support mechanisms, down to the nitty-gritty planning and reporting, and peer support. EASRO appreciates and understands the challenges. “They work with us and push us to the next step – and we say, ‘this is possible, this is not possible’.”

Area of Investigation 9: COVID-19

Evaluation Question 9: To what extent has the MHTF been able to respond to emerging and evolving needs of national health authorities and other stakeholders at national and sub-national level due to the COVID-19 pandemic?

Sub-questions:

- To what extent have MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRH services amidst the pandemic to ensure access to a continuum of comprehensive life-saving maternal and sexual and reproductive health services as part of the COVID-19 response and recovery efforts?
- To what extent did the MHTF reallocation of funds and reprogramming help maintain the continuity of SRMNH services, in particular maternity services; ensure the protection of healthcare workers (in particular obstetricians, midwives and anaesthesiologists); and strengthen the SRMNH coordination mechanisms in response to COVID-19 at national and sub-national levels?

Evaluation Criteria	<i>Relevance, efficiency, coordination, sustainability</i>
Rationale	In 2020, the COVID-19 pandemic spread to every country in the world leading to a range of complex and far-reaching health, socio-economic and other impacts. COVID-19 affected the health system and equitable access to MNH and SRHR services in detrimental ways. UNFPA working alongside other partners adopted a flexible approach to ensure continuation of access to RMNCAH services. The reprogramming and reallocation of funds, combined with mobilisation of additional resources for the emergency response, was aimed at mitigating the negative effects of COVID-19 on the ability of the health system to deliver quality MNH and SRHR services and to ensure continuous access to those services. MHTF partner countries pivoted their health system capacity to prevent, identify, treat and manage COVID-19 cases. UNFPA, including the MHTF, like other United Nations agencies and global partners, took steps to support countries to respond quickly and effectively to COVID-19 while ensuring the continuity in the provision of essential services.

Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR serviced amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts	
Indicators:	
<ul style="list-style-type: none"> • Number of MHTF funded assessments conducted on continuity of essential and lifesaving RMNCAH services amidst COVID-19 pandemic • Documented and reported adjustments in MHTF programmes in terms of scope, timing, and targeted outcomes in light of the pandemic at global and country levels • Examples of joint work by thematic teams within MHTF and across UNFPA to prioritise and address the COVID-19 related needs of partner countries • Examples of how MHTF processes, activities and goals continued to be delivered even during the COVID-19 response where that was possible • Examples of policies and programme adjustments related to practical changes and reorganisation of processes or systems • Participation by UNFPA and the MHTF in studies and reviews to assess the impact of COVID-19 on women and adolescents and identify critical needs for support to them as the COVID-19 pandemic unfolded • Incorporation of the response to COVID-19 impacts into annual MHTF plans and budgets. 	
Observations	Sources of Evidence
<p>UNFPA support for guidelines for service continuity</p> <ul style="list-style-type: none"> • UNFPA estimated that 1,269,817 pregnant women in the country face increased challenges in accessing lifesaving SRH services. The long period of school closure and lockdown measures contributed to increased teenage pregnancy rates by 1.55 per cent (in UNFPA supported districts). The Uganda Police reported a 10% increase in cases of GBV in 68 districts and a 17% increase in SGBV cases nationally, attributing it to a combination of increased tension, stress and confinement conditions in the household. • “With the introduction of the COVID-19 SOPs, UNFPA worked with MoH to produce guidelines for continuity of health services as well as online content and training materials (Quality of Care) that could be accessed by health workers remotely. Using the online applications, interventions on capacity building and coordination were not greatly affected. COVID-19 Pandemic caused suspension and postponement of most of the activities and change in means of engagement in compliance with the COVID-19 Prevention and Control guidelines especially for activities that require gathering of people like fistula repair camps. Using Online platforms for training and coordination was a challenge for participants living away from the urban centres due to the fact that internet access is limited in these areas.” (p.20) 	UNFPA Uganda, Final Annual Report for MHTF, 2020
<ul style="list-style-type: none"> • UNFPA support the MoH with PPE materials, they supported continuation of essential services, the implementation of the national guidelines to support the continuation of the essential services. They also did continued advocacy for the continuation of essential services at the district level. 	Interview, MoH official, Kampala, May 2021
<ul style="list-style-type: none"> • UNFPA has made a significant contribution to MoH efforts to improve policies and strategies for MNH, including the national PPH Action Framework, the RMNCAH Investment Case/Sharpened Plan (GFF), National MPDSR Costed Implementation Plan (see details further below), the RMNCH COVID-19 National Guidelines (Provision of RMNCAH Services during the COVID-19 Pandemic) and the National Guidelines for Continuation for Essential Services. 	Interview, MoH official, Kampala, May 2021

Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR serviced amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts	
<ul style="list-style-type: none"> In addition to the policies, UNFPA provided significant support alongside other partners to ensure the continuation of RMNCAH services during COVID-19: “Partners came into restore essential services during COVID-19, a lot of the support came from UNFPA.” In the early days, during lockdown, there were gross restrictions in access, because of restrictions of movement, so there was low performance, very low uptake of family planning. Of all the MNCH indicators, FP had the biggest drop, the FP uptake was very low, especially in April 2020. It recovered from June and above, when MoH came in to establish the weekly meetings for “continuation of essential services” and many partners came in to support the response and to ensure continuation of essential (including SRHR) services. Many partners were reprogramming of resources. “I remember we ran out (uterotonics – drugs to control PPH, and also magnesium sulphate – UNFPA buffered up of that. Second leading cause of maternal deaths is hypertensive disorders in pregnancy. The cost of uterotonic increased during that time; normally it costs 3.000 but went up to 20000, Ugandan Shillings, per private partners.” Partners came into restore essential services during COVID-19; a lot of the support came from UNFPA 	
<p>Service provider perspectives</p> <ul style="list-style-type: none"> During COVID-19, UNFPA procured several items for EMONC including PPE to help continue maternal health services and protect health workers. 	Interview, MoH Service provider, Kampala, May 2021
<ul style="list-style-type: none"> Gulu is one of the four districts that received UNFPA COVID-19 support in 2020 for PPE/IPC for midwives. COVID lockdown had major impact on access to MNH services – people only came for emergency services, while routine services such as ANC and immunizations dropped significantly during the first month of the lockdown. There were also travel/transportation restrictions. Led to more maternal deaths during that period. UNFPA supported the district with PPE for midwives to ensure that they could continue MNC services during this period. Boda-bodas and DHO vehicles (including ambulances) received “stickers” from MoH allowing them to circulate even though all public and private transportation was prohibited for 2 months (mid-March – end May) 	Interview, MoH service providers, Gulu District, May 2021
<ul style="list-style-type: none"> “Last year, when COVID-19 pandemic broke out, UNFPA engaged ... I am happy that UNFPA is on the ground, we work together all the time. With the lockdown that was imposed, it was very difficult for mothers to access health facilities.” UNFPA provided critical support to ensure the protection of health care workers, the continuation of SRHR service provision during the lockdown, as well as referrals access to those services by communities who could not reach the health facilities by their own means. Examples: UNFPA support to the two additional ambulances was “very critical support” and helped saving mothers’ lives during the COVID-19lockdown because they helped “pick the women at designated points who could not come to the health facilities themselves because of transport restrictions”. UNFPA also funded “fuel cards” to facilitate transportation of health workers to communities (to identify/map pregnant women and conduct outreach services) and referrals/ambulance services to help transport patients to health facilities – since all public and private transportation was banned during a two-month period. 	Interview, MoH service providers, Lawmo District, May 2021

Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR serviced amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts	
<ul style="list-style-type: none"> Also, the “fuel cards” were used to support the UNFPA ambulance to pick up blood supplies from the blood bank in Gulu city centre (150 km from Lamwo) as blood supply became very scarce during the COVID lockdown. UNFPA provided PPE for MNH health care workers including facemasks, surgical masks, gumboots, gloves, heavy duty gloves, sanitisers etc. (UNICEF also provided similar support). This helped protect clinical providers and as a result, only very few were infected with COVID-19 (there were more infected support/admin/cleaning staff). Before COVID-19 broke out, biweekly health partner coordination meetings were held in the district where the clinical teams would meet separately every two weeks, e.g., partners in nutrition, WASH, FP/MCH etc. would meet separately. When COVID-19 broke out, this got disrupted. “But we have now resumed, especially with partners in MCH services – we now meet every month – we have had two meetings so far. UNFPA has always been in attendance, we invite them, and they always come to attend, and they guide us a lot. They are a big partner with many programmes and districts, but still they spare time to come and participate.” 	
<p>UNFPA support for service continuity</p> <ul style="list-style-type: none"> The MoH work plan was revised to incorporate the supported COVID-19 response activity on training in IPC and follow up. A total of 159 service providers, especially midwives in four identified districts of Gulu, Otuke, Pader and Omoro were trained and mentored in IPC measures. UNFPA mobilized resources to procure PPEs worth USD 464,165 for health facilities in 46 districts and supported 1,579 health workers with transport to health facilities in 28 districts. USD 134,829 was used to purchase fuel for ambulances to provide transport to access SRH services in 32 districts. Districts were supported to procure fuel cards to facilitate referrals during the COVID-19 epidemic. 5000 mothers supported with referral. A Total of 4,791 women were supported from 55 UNFPA districts, of these, 2,668 mothers were supported using MHTF Funds with transport to deliver in Gulu and Pader districts during the period of lockdown and 51 mothers were supported to receive emergency obstetric care in the same period. UNFPA supported the conduct of IPC measures including training and mentoring of service providers particularly midwives, in COVID-19 infection prevention and control strategies and linkages to SRH and GBV, availability, printing, dissemination of IEC materials and risk communication. Prevention of COVID-19 transmission was enhanced through training in IPC in 6 districts, provision of IEC materials on COVID-19 (17,700 pieces of IEC materials on COVID-19 both in English and local languages were printed and distributed in 55 districts including the four districts of Gulu Omoro, Pader and Otuke under MHTF). 	UNFPA Uganda, Final Annual Report for MHTF, 2020
<ul style="list-style-type: none"> Entries for progress against workplan indicators/activities were noted as “0 per cent completion.” 	UNFPA Uganda, GOU/UNFPA Country Program Support to MoH 2020 Annual Work Plan, 2020
UNFPA perspective	Interview, UNFPA Uganda national staff, May 2021

Assumption 9.1: MHTF programmes pursued a flexible and adaptive approach to generate evidence on the availability of SRHR serviced amidst the pandemic and to ensure continued access to a continuum of essential life-saving sexual, reproductive and maternal health services as part of the COVID-19 response and recovery efforts	
<ul style="list-style-type: none"> “I believe we have played a great role in ensuring “continuation of essential service” – in supporting mechanisms that were in place, TWG, there has been a lot of support for policy development. Two, at the service delivery level, we made a very deliberate move to support the different DHOs with fuel and money/cash to ensure safe delivery services.” 	
Assumption 9.2: MHTF reallocation of funds and reprogramming helped maintain the continuity of lifesaving SRMNH services, particularly maternity services/units	
Indicators:	
<ul style="list-style-type: none"> National and subnational data DHIS2/HIMS indicate continuation of SRMNH services, in particular in maternity units Reported (quantitative and qualitative) effectiveness of UNFPA support to procurement, distribution and use of PPE by health care providers (in particular obstetricians, midwives and anaesthetists) to protect them against COVID-19 infections Examples of UNFPA support to SRMNH coordination mechanisms at national and sub-national level which has helped to prevent overlap/duplication and enhance complementarity and synergies with other SRMNAH programmes and actors. 	
Observations	Sources of Evidence
Reprogramming 2020 MHTF resources <ul style="list-style-type: none"> “Through the reprogramming of the MHTF the CO was able to support the procurement and distribution of the much-needed personal protective equipment (PPEs) for midwives to continue offering essential services during COVID-19 pandemic. In addition, through this reprogramming, a total of 16,347 pregnant women were able to receive services (ANC, delivery and EmONC) due to the successful provision of transport to health workers to access health facilities and pregnant women to seek medical care during the total lockdown at the onset of COVID-19 pandemic in Uganda. A total of 159 service providers, especially midwives in four districts of Gulu, Otuke, Pader and Omoro were trained and mentored in COVID-19 infection prevention and control strategies while administering the SRH and GBV services. In addition, IEC materials were generated to promote risk communication in these districts.” (p.4) “Infection Prevention and Control was strengthened in the context of COVID-19 with the training of 159 service providers (especially midwives), in four districts of Gulu, Otuke, Pader and Omoro. These healthcare providers were also trained and mentored in the provision of SRH and GBV services.” (p.6) “Infection Prevention for COVID-19 has significantly reduced cases of Sepsis in maternal care across the country.” (p.19) 	UNFPA Uganda, Final Annual Report for MHTF, 2020
<ul style="list-style-type: none"> Funds earmarked to support the MoH to develop, produce and disseminate a documentary on the Midwifery programme in Uganda to make the International Year of the Midwife was reallocated to support MHTF salaries. Funds initially earmarked to support attendance at the 1) International Society of Obstetric Fistula Surgeons conference and Obstetric Fistula Global TWG meeting in Maputo; 2) International Confederation of Midwives conference in Bali; and Global MHTF and EmONC meetings were reallocated towards the COVID-19 response. 	UNFPA Uganda, MHTF 2020 Mid-year Report, 2020

Assumption 9.2: MHTF reallocation of funds and reprogramming helped maintain the continuity of lifesaving SRMNH services, particularly maternity services/units

- **Funds were reallocated to the COVID-19 response from EmONC activities**, i.e., to support the MoH to mentor service providers in provision of quality EmONC services, including the roll out of the Quality-of-Care standards in one target district as per the road map for quality of maternal care in Uganda.

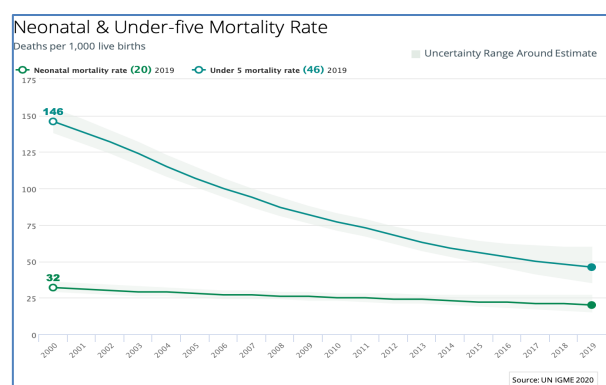
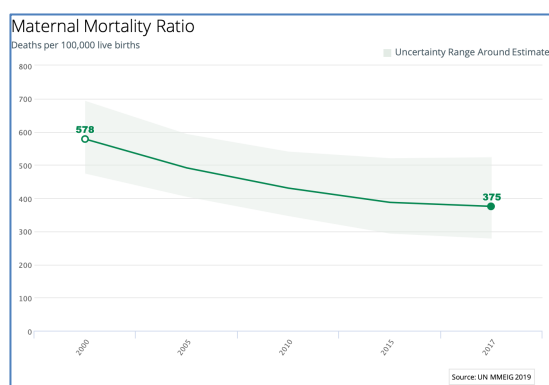
ANNEX 2: PERSONS INTERVIEWED IN UGANDA

Name	Organization	Position
Dr Mugani	MoH Kampala	Assistant commissioner reproductive and infant health
Dr Robert Mutumba	MoH Kampala	Principle medical officer
Emily Bako	MoH Kampala	Principle nursing officer
Wilberforce Mygwanya	MoH Kampala	UNFPA secondment to MoH for M&E – Reproductive health and Infant health
Dr Lawrence Kazibwe	MoH Kampala	Director, Kawempe NRH
Dr Safina Musene	MoES, Kampala	Commissioner, Business, Technical, Vocational Education and Training
Tina Makimera	MoES, Kampala	Responsible for education of health cadres
Martin Opolot	Uganda Midwives & Nurses Council	IT specialist
Alain Siebenaler	UNFPA CO, Kampala	Country representative
Dr Edson Muhwezi	UNFPA CO, Kampala	Assistant representative
Christine Kajungu	UNFPA CO, Kampala	Programme specialist – Maternal health
Maria Najjemba	UNFPA CO, Kampala	Programme analyst – Maternal health
Richard Mwesigwa	UNFPA CO, Kampala	MNCH/Fistula focal point
Rosemary Kindyomunda	UNFPA CO, Kampala	SRHR Integration focal point
Grace Myerwanire Murindwa	World Bank, Kampala	Technical advisor/GFF focal point
Charity [need last name]	SIDA, Sweden Embassy, Kampala	Acting PO SRHR, democracy and human rights
Judith Adokorach	The Netherlands Embassy	Policy officer, SRHR
Alice	Terrewode	unknown
Cindarella Anena	UNFPA field office for West Nile and Acholi Subregions, Lawmo district	Field coordinator
Grace Anena	MoH Gulu District	Assistant DHO/RMNCAH
Dr Denis Ochoula	MoH Lawmo District	District health officer
Takish Oroma	MoH Lawmo District	Assistant DHO/MCH
Christine Birabwa	Project Officer for Quality Assurance, Arua, West Nile	Marie Stopes Uganda
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Sister Dr. Nabukalu Anthony Imelda	St Joseph Kitovu Masala District, Western Uganda	Director of Fistula Programme

ANNEX 3: UGANDA COUNTRY DATA PROFILE

General and Health Financing Profile					
Indicator	Value	Source	Indicator	Value	Source
Total Population: estimated size of population at mid-year, in millions, 2021	47.1	(1)	Life expectancy at birth in years, 2021 (male/ female)	62/66	(1)
GNI per capita, Atlas method (current USD) 2019	780	(3)	Current health expenditure as per cent of Gross Domestic Product, 2018	7%	(2)
Primary Health Care expenditure as per cent of current health expenditure, 2018	59%	(2)	Domestic general government health expenditure (% of current health expenditure/ % of general government expenditure)	16%/ 5%	(3)
Out-of-pocket expenditure (% of current health expenditure) 2018	38%	(3)	External health expenditure (% of current health expenditure)	43%	(3)

Health and population profile		
Indicator and Definition:	Indicator value	Source
Total fertility rate: Number of children born per woman in her lifetime.	4.6	(1)
Average annual rate of population change: Average exponential rate of growth over one year based on a medium variant projection	3.6	UNFPA calculation based on data from United Nations Population Division
Maternal mortality ratio, 2017: Number of maternal deaths per 100,000 live births	375	(4)
Neonatal mortality rate (deaths in babies in the first month of life per 1000 live births) 2019	17	(3)
Births attended by skilled health personnel, 2017: Percentage of births attended by skilled health personnel (doctor, nurse or midwife)	74	(5a)
Contraceptive prevalence rate, modern method (CPR): Percentage of (all) women aged 15-49 who are currently using any modern method of contraception	35	(1)
Unmet need for family planning: Percentage of (all) women aged 15-29 who want to stop or delay childbearing but are not using a method of contraception	19	(1)
Adolescent birth rate, 2020: Number of births per 1,000 adolescent girls aged 15-19	132	(1)
Child marriage by age 18, 2019: Proportion of women aged 20-24 years who were married or in a union before age 18	34	(5b)



(1) United Nations Population Division <https://www.unfpa.org/data/world-population-dashboard> (2) World Health Organization Global Health Expenditure database <https://apps.who.int/nha/database/ViewData/Indicators/en>; (3) World Bank Data Bank: <https://databank.worldbank.org/home> accessed on 28 June 2021; (4) UN Interagency group for maternal mortality estimation <https://www.who.int/data/gho/indicator-metadata-registry/imr-details/26> (5) UNICEF (a) <https://data.unicef.org/topic/maternal-health/delivery-care/> (b) <https://data.unicef.org/resources/dataset/child-marriage/> (6) Source of graphics: <https://profiles.countdown2030.org/#/ds/UGA>

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