

**Evaluation of the project
“Saving Maternal and Newborn
Lives in Refugee Situations”
in Cameroon, Chad and Niger**

**EVALUATION REPORT
AUGUST 2021**

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List of abbreviations

ADES	Association for Economic and Social Development
AHA	Africa Humanitarian Action
ANC	Antenatal care
APBE	Action Pour Le Bien Être
BEmONC	Basis Emergency Obstetric and Neonatal Care
BMGF	Bill and Melinda Gates Foundation
CAR	Central African Republic
CB	Capacity Building
CSSI	Centre de Support en Santé Internationale
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHW	Community Health Worker
DPSM	Division of Programme Support and Management
EBF	Exclusive Breast feeding
EIBF	Early initiation of Breastfeeding
EmONC	Emergency Obstetric and Neonatal Care
FP	Family Planning
HBB	Helping Babies Breathe
HBS	Helping Babies Survive
HCW	Health Care Worker
HF	Health Facility
HIS	Health Information System
HMS	Helping Mothers Survive
HQ	Headquarters
IDP	Internally Displaced Persons
IMC	International Medical Corps
IPC	Infection Prevention and Control
IRC	International Rescue Committee
KEQ	Key Evaluation Question
KII	Key Informant Interview
KSA	Knowledge Skills Attitudes
LCHI	Low-Cost High Impact
LDHF	Low Dose High Frequency
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Rate
MNC	Maternal and Neonatal Care
MNH	Maternal and Neonatal Health
MoH	Ministry of Health
MT	Master Trainer
NMR	Neonatal Mortality Rate
PHS	Public Health Section
PHO	Public Health Officer
PNC	Postnatal care
PPE	Personal protective equipment
PSP	Private Sector Partnership
RMCNH	Reproductive Maternal Child and Neonatal Health
RST	Respondent-driven Sampling Technique
SARA	Service Availability and Readiness Assessment
SB	Stillbirth

SBR	Stillbirth Rate
SDG	Sustainable Development Goal
SES	Socioeconomic Survey
SRH	Sexual and Reproductive Health
TBA	Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WCA	West and Central Africa
WHO	World Health Organisation

Executive summary

Overview of project and purpose of the evaluation

The United Nations High Commissioner for Refugees (UNHCR) commissioned this evaluation for the purpose of accountability and learning to inform future similar interventions. It examines the relevance, effectiveness and sustainability of the UNHCR and Bill and Melinda Gates Foundation (BMGF) project: “Saving maternal and newborn lives in refugee situations”, implemented in three refugee operations in Chad, Niger and Cameroon between April 2018 and December 2019. To assess sustainability and the impact of COVID-19, the evaluation period was extended to September 2020.

- **Background**

The project evaluated is an expansion of an initial two-year project “Saving Newborn Lives in Refugee Settings”, implemented in refugee camps in South Sudan, Kenya and Jordan between January 2016 and October 2017, also with the support of the BMGF. Chad, Niger and Cameroon were selected for the expansion due to their poor maternal and neonatal health indicators and low resource settings. UNHCR worked with six partner NGOs and Ministries of Health across the three countries. The project targeted around 772 000 refugees: 272 000 in Cameroon, 430 693 in Chad, and 69 000 in Niger. The project was implemented across 29 health facilities (21 at the primary level and 8 at the secondary level) and through complementary community health activities in largely stable/fragile contexts and both camp and non-camp contexts in the countries.

- **Evaluation design, methods and limitations**

The evaluation was based on a mixed method design and followed a phased-approach including inception, data collection, data analysis, and reporting. The data collection phase included a desk review of internal and external relevant documentation. Qualitative data was collected through a literature review, semi-structured key informant interviews and a co-creation workshop conducted remotely. A total of 44 stakeholders were interviewed, including UNHCR regional and country staff, BMGF representatives, partners and project staff and a very small number of beneficiaries. An important limitation to the evaluation was the inability to travel to project sites due to restrictions associated with the COVID-19 pandemic.

Key results and conclusions

- **Design**

The design was found to be very pertinent, including the use of a comprehensive baseline assessment allowing for appropriate alignment to population needs and contextual realities. The low-cost, high-impact (LCHI) interventions throughout the continuum of care and the Low Dose High Frequency (LDHF) training approach were highly relevant to the contexts and well aligned with the UNHCR and BMGF strategies and goals. The overall design was comprehensive, well developed and adaptable to changing needs and constraints. The inclusion of Community Health Workers (CHW) to aid with community sensitization and

follow-up with mothers and babies was also an important element of the design. A primary limitation of the design is the limited availability of local resources, notably insufficient funding for district hospitals. At the design phase, more emphasis on Comprehensive Emergency Obstetric Care at referral facilities and allocating additional time to consolidate the learning of facility staff would have further strengthened the project.

- **Implementation**

Overall, the implementation was found to be effective due to strong collaboration and coordination with national ministries of health and NGO partners, and the high degree of adaptability of the project. The different models of capacity building included: “Helping Mothers Survive” (HMS), “Helping Babies Survive” (HBS) and the Low-dose high-frequency (LDHF) training model for training health workers and CHWs. These approaches were catalytic for the implementation of quality service delivery and demand generation. The recruitment of an international consultant for training, supervision and mentoring also served to strengthen the provision of quality care.

Improvements to health facility infrastructures, reliable procurement and supply of materials and drugs, and supportive training and supervision collectively contributed to improved service delivery. In all three countries, the maternal and neonatal service delivery package was comprehensive, and introducing the Kangaroo Mother Care (KMC) was innovative. Some constraints to implementation included the turnover of newly trained staff and delays in implementation associated with delays in budget disbursement. External barriers included persisting low acceptance of, and demand for, contraception at the community level, especially in Cameroon and Chad. The emergence of the COVID-19 pandemic and ongoing insecurity (particularly in Niger) affected implementation effectiveness.

- **Impacts and outcomes**

Analysis of the results indicate that the provision and the quality of comprehensive neonatal care, from neonatal resuscitation to caring for small and sick babies, improved in all countries. Neonatal mortality rates dropped below the set target of 25% and demonstrated decreasing trends in all countries. All three countries managed to decrease the case fatality rate (CFR) for neonatal complications over the course of the first phase of the project. The project exceeded expectations for the use of Kangaroo Mother Care (KMC). Of the health facilities, 100% provided KMC and nearly all newborns weighing less than 2 000g were placed in KMC with their mother or another caretaker. Stakeholders vouched for the critical role played by Community Health Workers (CHWs), for home-based follow-up, referrals in case of complication, and sensitisation to Maternal and Newborn Health, though this was not verifiable through available metrics. The direct obstetric case fatality rate - considered a quality indicator at facility level - meets acceptable rates. However, assessment of the impact of project activities on maternal mortality rates would require analysis of more robust data from longer-term implementation. Contraceptive uptake by first time users remained lower than targeted, except in Niger.

In Niger, the existing program “École des maris” was key to addressing community acceptance of and demand for family planning (FP).

Overall, the project improved the quality of Maternal and Newborn care (MNC) and FP, and increased access to Maternal and Neonatal Health (MNH) services, training materials, medication, medical supplies and contraceptives. Project reach extended beyond refugee populations, improving host populations’ access to quality services.

- **Budget**

Overall, planned activities were implemented within the foreseen timeline. Output targets were met in line with the allocated budget and no major budget gaps were identified. Challenges external to the project revealed insufficient existing funds within the wider local health systems, affecting procurement of basic staff and material needs at health centres both in and outside of camps. Available data did not allow for calculation of the cost-effectiveness of program activities.

- **Sustainability**

The project’s prospects for sustainability are promising at multiple levels. First, within the existing project, improvements in infrastructure, material, equipment, training materials, medication, and the knowledge gained by health personnel are valuable midterm sustained results. Secondly, the involvement of ministries of health including regional directors was key to beginning the process of integrating knowledge and practice at the national level. LDHF trainings continued in two countries beyond the project period and core health indicators continued to show positive trends. Thirdly, at the global level, UNHCR made significant and successful efforts towards institutionalization and dissemination of project learnings.

Challenges to long-term sustainability of project activities and impact remain due to the gaps in national government systems’ capacity to sustain results beyond the life cycle of the project. Given the significant local needs and limited resources, continuity and expansion of funding and ongoing institutional strengthening and subsequent systemization were noted to be the main influencers in providing durable positive trends in MNH outcomes.

Lessons learned

- The baseline assessment provided an extensive understanding of the contextual health system needs and enabled the development of tailored project activities. The selection of some of the population-based mortality indicators should have been based on data availability and reliability.
- Master trainers for the LDHF trainings were selected from site-based facilities. This proved effective and ensured continuous and case specific mentoring for staff at health centres and contributed to sustainability of activities beyond the project period.

- The strengthening of CHWs' capacity helped ensure a continuum of care. The engagement of CHWs trained in MNH care helped address some of the cultural factors encountered during awareness-raising activities and home visits.
- The project's emphasis on KMC, a LCHI strategy new to the sites, resulted in high utilization of this approach.
- A dedicated project manager was engaged and proved important to ensure support to the Public Health Officers in the development, implementation, monitoring and evaluation of the project. In the future, a project manager could help create synergy and cross-country collaboration/learning.
- The project made the adjustments needed due to COVID-19 starting from March 2020. Modifications made included changes to health centres' waiting areas, purchase of protective gear for health workers, and restructuring of group project activities to respect social distancing regulations. As a result, COVID-19 only initially slowed down program activities.
- The project supported district referral hospitals which was essential to ensure timely access to caesarean delivery, blood transfusions and care for very small and sick newborns. Better monitoring of access to, availability and quality of comprehensive emergency obstetric and neonatal care (CEmONC), could have helped identify gaps in those activities during the project implementation.
- Monitoring and Evaluation (M&E) indicators and measures of project impact such as maternal mortality and morbidity needed to be commensurate with the project timeline.

Recommendations

1. **UNCHR and the BMGF should consider expanding the project for continued improvements in MNC and in FP for refugee populations in similar low-resource settings within the West and Central Africa (WCA) region.** This has cost implications particularly at the country, regional bureau and global levels.
2. **UNHCR should consider MNH project integration into wider UNHCR public health programming and greater support to national health systems** to further consolidate sustainability and systemization of project activities in line with the Global Compact for Refugees.
3. **UNHCR should consider strengthening the support it provides to partners in monitoring and evaluation (M&E) to enhance the quality of health data collected.** Based on the existing HIS and taking into consideration national data collection, further assistance to partner NGOs would align well with the roll-out of UNHCR's Results Based Management processes.
4. **Future interventions among refugee populations in similar settings should factor in the importance of addressing the persisting socio-cultural factors that affect behaviours in MNC and FP.** Issues and norms to consider addressing, include community resistance to acceptability and utilization of FP, as well as respect for gender and maternal rights.

5. **UNHCR should undertake a more strategic approach to its partnership with the BMGF (and other potential global health funders), one that is both transactional (based on funding), and non-transactional (based on a relationship of shared values and interests).** This would further require investment in dedicated staff to cultivate relationships and the development of stronger theories of change that demonstrate the impact/value that such a multi-year partnership might generate.

1. Introduction and background

This evaluation provides insights on the relevance, effectiveness, and sustainability of the “*United Nations High Commissioner for Refugees (UNHCR) projet: ‘Saving maternal and newborn lives in refugee situations’*” in three targeted refugee operations in Chad, Niger, and Cameroon and covers the project’s timeframe of April 2018 to the 31 December 2019. Beyond the project’s timeframe, the evaluation assesses issues of sustainability and the impact of the Covid-19 pandemic for the period January to September 2020. The purpose of the evaluation is to support, through robust and systematic analysis, ‘learning and accountability’ for UNHCRs’ future programming across three different levels: project-based implementation, project management and donors. This evaluation aims to provide lessons learned about the project, this particular approach to improving maternal and newborn health and how to incorporate this approach into the Public Health Section’s (PHS) strategy for replication in other refugee settings, as well as lessons learned for UNHCR on private sector partnerships and resource mobilization. The intended users of the evaluation are UNHCR PHS at Headquarters (HQ), UNHCR public health staff, the Regional Bureau for West and Central Africa, the Private Sector Partnerships (PSP) Service at HQ, and stakeholders in the project’s countries.

The evaluation has multiple objectives to:

- Assess project results and performance
- Identify internal and external factors influencing project implementation
- Explore the impact of the COVID pandemic on the project
- Explore programmatic sustainability
- Inform the Public Health Section’s strategies and guidance with regards to Reproductive Maternal Child and Neonatal Health (RMCNH)
- Provide actionable recommendations to inform future programming
- Assess UNHCR’s partnership with the BMGF
- Assess the use of funds coming from the Bill & Melinda Gates Foundation (BMGF)

Through its partnership with UNHCR, the BMGF has helped create innovative solutions to address forced displacement globally, and to ensure that refugees are not ‘left behind’.

The BMGF has engaged in the refugee cause since 2006, providing emergency response support to various refugee crises, and has also supported key programs that leverage the strengths of both UNHCR and the BMGF. The BMGF is committed to the provision of emergency relief and innovative technologies and approaches in water, sanitation and health for refugees, among other key initiatives. Their programs focus on building local capacity by implementing Low-Cost High Impact (LCHI) solutions. The “Waste to Value Sanitation Solutions for Refugee Camps in East and Horn of Africa” project explored sanitation technologies for refugee populations in camp settings, beyond the plastic pit latrine to improve sanitation solutions and enhance the health of refugees. UNHCR is working with the BMGF in Bangladesh to implement and plan for long term sustainable sanitation, health and energy solutions for refugees and host

communities. The BMGF partnership demonstrates the catalytic role that the private sector can play in making a positive long-term impact on the lives of refugees¹. In 2016, also with the support of the BMGF, UNHCR launched a two-year project 'Saving Newborn Lives in Refugee Settings', aiming to improve neonatal care services with a focus on LCHI newborn interventions in refugee camps in South Sudan, Kenya and Jordan. Findings of an evaluation in 2018 (covering the period Jan/2016 to Oct/2017), concluded that the project contributed significantly to positive results, including improved quality and availability of health care services to mothers and newborns in the refugee settlements. UNHCR then expanded the project to three West-African countries (Chad, Niger, Cameroon) with a high burden of diverse refugee populations (Sudanese, Central African Republic, Malian, and Nigerian refugees), living in refugee camps and/or out-of-camp settings. The expanded project added maternal health and family planning. The three countries were selected because of their poor maternal and neonatal health indicators and low resource availability. In addition, the countries had partners willing and capable of implementing the project, with UNHCR Public Health Officers (PHO) to manage, coordinate and monitor the project.

Target Country Profiles

Cameroon is a lower-middle-income country with a population of over 25 million (2018). It shares its borders with the Central African Republic, Chad, Equatorial Guinea, Gabon, and Nigeria. Cameroon's ruling party has long dominated the country's political landscape with the same president serving his seventh term since 1982. Cameroon suffers from weak governance, hindering its development and ability to attract investment. Having enjoyed several decades of stability, Cameroon has in recent years been grappling with attacks by Boko Haram in the Far North region and a secessionist insurgency in the Anglophone region. This has resulted in the internal displacement of almost 192 910 people in the Far North region together with some 86 000 Nigerian refugees in Cameroon, of whom 60 000 are accommodated in Minawao camp. In addition, some 259 100 CAR refugees remain in rural areas in the East, the North and Adamawa regions with 30 per cent living in seven organised sites and 70 per cent accommodated by host communities, scattered in local villages. This adds significant complexity to monitoring the health situation and gathering health activities and indicators although the pace of influx of CAR refugees reduced during 2016. Some 23 600 refugees and asylum seekers further reside in urban areas, mainly in Douala and Yaoundé.²

Chad is a landlocked Sahelian country and grapples with security challenges associated with the conflicts in bordering countries. The recent death of Chad's former President and installation of a transitional military council under his son has injected further instability. Déby and his party had dominated Chadian politics since December 1990. Chad's economy remains fragile and is vulnerable to considerable risk such as oil price volatility and ongoing regional insecurity. Key sectors, such as infrastructure, education, and health all lack sufficient investment. Chad is home to some 400 000 refugees, 310 000 of which are from Darfur (Sudan) and another 70 000 from the Central African Republic (CAR) representing approximately 4% of

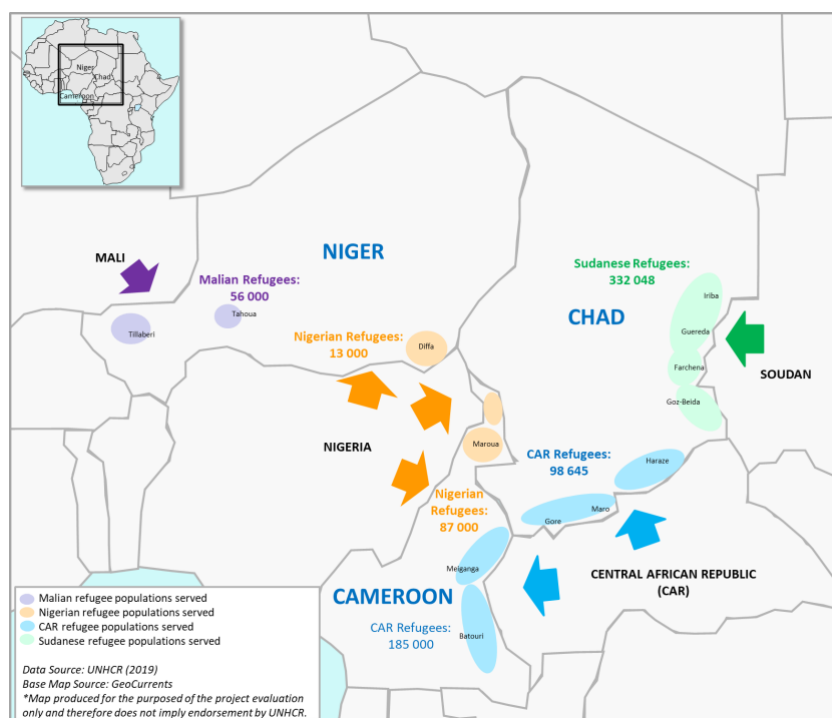
¹ Source: <https://www.unhcr.org/bill-and-melinda-gates-foundation.html>

² <https://www.worldbank.org/en/country/cameroon/overview#3>

the country's total population. Those from Sudan have been arriving since 2002 and are accommodated in 10 refugee camps in the East, while those from CAR have been displaced for more than 10 years and are accommodated in seven camps in the South. The country has also received around 15 000 refugees from Nigeria due to of the violence perpetuated by Boko Haram³.

Niger is located in the heart of the Sahel region and is classified as extremely low income faced with recurring crises arising from the country's security and ongoing humanitarian issues. Despite significant strides made by Niger over the past decade, the country's extreme poverty rate has remained very high, affecting more than 10 million people. Niger went through its first democratic transfer of power in 2021. The ongoing security crises threaten to undermine the progress made by Niger in terms of economic growth. Niger provides asylum and refuge to over 165 000 refugees fleeing conflict and persecution in neighbouring Mali and Nigeria. The Diffa region of Niger has been hosting Nigerian refugees fleeing terrorist violence in the northern states of Niger since 2013. The situation deteriorated dramatically in 2015, with the first attacks on Niger territory in February 2015, resulting in a situation where Nigerian refugees, returnees, and Internally Displaced Persons (IDPs), were all mixed. The majority of displaced persons are currently living in spontaneous sites along the one main road in the region, while others have settled in local towns and villages with host families. UNHCR has established two camps, Sayam Forage and the IDP camp of Kabelawa. Since January 2012, following violence, hostilities, human rights violations and a rapidly deteriorating humanitarian situation in the northern part of Mali, some 50,000 Malians are now hosted by Niger.⁴

Map: UNHCR-BMGF Project Regions and Refugee Populations Served in Chad, Niger, Cameroon (2018-2020)



³ <https://www.worldbank.org/en/country/chad/overview>

⁴ Source : <https://www.worldbank.org/en/country/niger/overview>

Maternal and Neonatal Health, and Family Planning Indicators

The three countries face significant maternal and neonatal health challenges. Although maternal mortality rates (MMR) are decreasing, the pace is slower than optimal, with annual rates of MMR reductions of 1.2% in Chad, 2.6% in Niger and 2.9% in Cameroon between 2000 and 2017⁵. MMR range from 509 per 100 000 live births in Niger to 1 140 per 100 000 live births in Chad. (Figure 1) Reaching the Sustainable Development Goal (SDG) target of a Maternal Mortality Rate of less than 70/100.000 live births by 2030 will be challenging, especially for Chad.⁶

Neonatal mortality rates (NMR) ranged from 25 (per 1 000 live births) in Niger, to 27 in Cameroon and are as high as 34 in Chad⁷ (HNN 2018 data). In 2015, stillbirth (SB) rates in the three countries ranged between 20 and 43 per 1 000 births. (Figure 2)

Figure 1. Maternal mortality ratio 2017

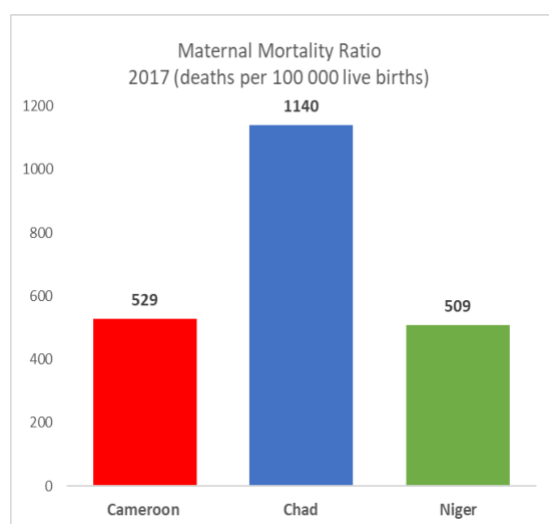


Figure 2. Neonatal mortality and Stillbirth rates

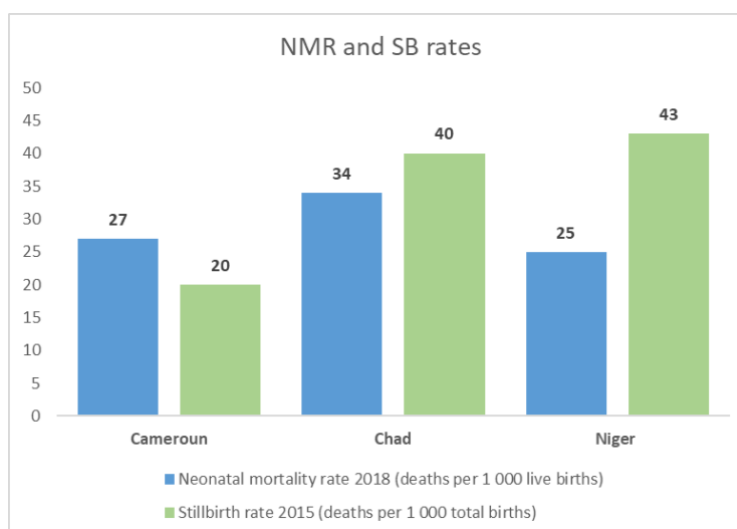


Table 1. Maternal health, FP and coverage indicators (<https://www.healthynewbornnetwork.org/numbers/>)

MATERNAL HEALTH AND COVERAGE INDICATORS					
	Demand for family planning satisfied with modern methods 2013-2018	Antenatal care coverage, > 1 2013-2018	Antenatal care coverage, At least 4x 2013-2018	Institutional delivery 2013-2018	Deliveries by C-section 2013-2018
Cameroon	47%	82.8%	58.8%	61.3%	2.4%
Chad	20.2%	54.7%	31%	21.7%	1.4%
Niger	45.5%	82.8%	38%	58.8%	1.4%

Project Overview

The project targeted almost 772 000 refugees: 272 000 in Cameroon, 430 693 in Chad and 69 000 in Niger. (See Annex 1 for country maps) In Cameroon, the project was implemented in nine Health Facilities

⁵ Source: <https://www.healthynewbornnetwork.org/numbers/chart-builder/>

⁶ Source: *Ibid*

⁷ Source: *Ibid*

(HF), 15 in Chad and 5 in Niger. In total, UNHCR worked with six health partners for the implementation of the project. Most of the Primary Health Care facilities serve mainly or only refugees, but all are integrated within the Ministry of Health (MoH) system. The Health Centres (HC) in the camps that only serve refugees are still integrated with MoH. Integration was either full or partial in all sites. Many health centres were set up years ago for the refugee population and were only integrated with MoH in the past few years. The project supports ongoing primary health care provision in the selected refugee sites with the aim of improving the quality of care and demonstrating the value added of the project approach (Table 2).

Table 2. Project's target populations

SAVING MATERNAL & NEWBORN LIVES IN REFUGEE SETTINGS' TARGET POPULATION						
Host Country	Region	Nb pop	Country of origin	Partner NGO	Primary Health Centres	District Hospitals
Cameroon	East	185 000	CAR	Africa Humanitarian Action (AHA)	5	3
	North	87 000	Nigeria	International Medical Corps (IMC)	1	
	Total	272 000			6	3
Niger	South	13 000	Nigeria	ABPE	1	
	West	56 000	Mali	Action Pour Le Bien Etre (APBE)	4	
	Total	69 000			5	
Chad	South	98 645	CAR	Centre de Support en Santé Internationale/ Association for Economic and Social Development (CSSI/ADES)	5	3
	East	332 048	Sudan	International Rescue Committee (IRC)	5	2
	Total	430 493			10	5
GRAND OTAL		771 493			21	8

The BMGF awarded \$2 501 299 for each of the three countries for 2 years (2018-2019), for a total project cost of \$7 335 290. An extension was granted until the end of June 2021 with a budget increase of \$477 836.

UNHCR aims to ensure that all refugees are able to fulfil their rights in accessing life-saving and essential health care, HIV prevention, protection and treatment, reproductive health services, food security and nutrition, and water, sanitation and hygiene services. UNHCR is committed to improving access to comprehensive reproductive, maternal and newborn health services, as well as increasing the use of innovative and appropriate technologies in reproductive health services. As a result, UNHCR has been providing maternal, neonatal and family planning services in all its operations. This project emphasizes the expansion of LCHI interventions to address maternal and newborn health. These include the use of the partograph, active management of third stage labour (AMTSL), hygienic cord care, thermal care, initiation of breathing and resuscitation, early initiation of exclusive breastfeeding (EIEBF), kangaroo mother care (KMC), training and support of Community Health Workers (CHW) in conducting pre- and post-natal home visits, and eye care. In addition, the project aims to improve access to, and acceptability of, contraception/family planning and other components of Emergency Obstetric and Newborn Care (EmONC). The primary output of the project was the improvement of maternal, newborn care and contraceptive services in refugee settings with a primary focus on **essential low cost, high impact newborn practices (including KMC), improving quality and availability of EmONC services and increasing the use of modern family planning methods**. The ultimate goal of the project is to save maternal and newborn lives in refugee camps/settlements with high levels of maternal and neonatal

mortality. The project incorporated the lessons learned and the recommendations made after the evaluation in the previous three countries (Jordan, South Sudan and Kenya). This project further aimed to roll out and improve standardized training materials, tools and protocols already utilized in similar refugee settings globally.

Table 3 summarizes the Project Results Framework, the primary and intermediate project outcomes and outputs.

Table 3. Project Results Framework

Primary Outcomes	Intermediate Outcomes	Outputs
Understanding of the specific situation of the new-born, maternal health care and family planning services and barriers has been achieved	Baseline assessment, monitoring and evaluation conducted	
Quality, comprehensive essential new-born health care provided	Capacity building of human resources: training of the health providers and community based health workers on essential new-born interventions strengthen	Training of facility and community based health workers on essential new-born health interventions
	Adequate maternal supplies, equipment and guidelines/protocols provided to health clinics according to the level have been provided	Provision of supplies, equipment and guidelines/protocols
Quality, comprehensive maternal health services are provided	Capacity building of human resources: training of the health providers and community based health workers on emergency obstetric care, antenatal and postnatal care strengthen	Training of facility and community based health workers on EmONC, antenatal and postnatal care interventions
	Adequate maternal supplies, equipment and guidelines/protocols provided to health clinics according to the level have been provided	Provision of supplies, equipment and guidelines/protocols
Quality, comprehensive family planning services improved	Capacity building of human resources: training of the health providers and community based health workers on contraceptive counselling, contraceptive modern methods and sensitization and promotion strategies strengthen	Training of facility and community based health workers on counselling and modern family planning interventions
	Adequate maternal supplies, equipment and guidelines/protocols provided to health clinics according to the level have been provided	Provision of supplies, equipment and guidelines/protocols

In sum, the project’s focus on maternal and neonatal health among refugees helped address multiple social and economic factors affecting vulnerable women and infants, including women’s reproductive rights and mothers’ and newborns’ access to quality care.

UNHCR Institutional Changes

It is important to note that in early 2020, a new organizational design and way of working was put in place at UNHCR, including the decentralization and regionalization process, with the creation of seven field-based regional bureaux. UNHCR’s transformation is aimed at strengthening the organization and better positioning it to deliver on its mandate. The rationale and motivations for these changes are:

- To place capacities, authorities and resources closer to the people the agency serves;

- To respond to the need for a more comprehensive, predictable and equitable international response to large-scale refugee movements;
- To improve the effectiveness and efficiency of humanitarian action, to draw on more resources from a wider range of stakeholders including development actors and to strengthen the participation of populations of concern in decision-making, and;
- To better position the organization to protect and assist populations of concern, work with others to promote solutions, address future challenges and take advantage of emerging opportunities.

Another key initiative is the results-based management (RBM) revision project, which has evolved from a relatively straightforward attempt to improve or replace Focus (UNHCR's programme planning and reporting tool), to a more ambitious effort to transform the way results and impact are measured and used to inform future strategic planning. The roll-out of the project being evaluated has taken place against this backdrop of change.

2. Evaluation approach, methods and limitations

The evaluation framework (Annex 2) was developed around the three areas of enquiry with six high-level evaluation questions and a series of sub-questions. The three main areas of enquiry are:

- 1) Design (model and strategy)
- 2) Implementation (delivery, inputs, outputs, processes and partnerships)
- 3) Performance (results, outcomes, sustainability and funding partnerships)

A mixed methods approach was used for data analysis. While most of the data collected was qualitative, the team analysed secondary quantitative data to inform Maternal and Newborn Health Care and Family Planning service accessibility, utilisation and quality of care. The evaluation ensured methodological rigor through: (i) the use of a combination of evaluation tools and multiple analytical methods, as well as the collection of both primary and secondary data, and (ii) triangulation of evidence across multiple data sources. All participant selection followed a purposeful sampling technique. Throughout the evaluation respondent-driven sampling techniques (RST) were applied to obtain additional key informants.

The methods of data collection, analysis and reflection included review of documents and literature (see Annex 3), semi-structured key informant interviews (see Annex 4 and 5), project quantitative data, and a participatory co-creation workshop to inform recommendations (Table 4). Remote semi-structured Key Informant Interviews (KIIs) with different categories of stakeholders generated rich insights, meaning and understanding across the different areas of enquiry in the evaluation framework. Question guides were developed according to stakeholder group. A validation and co-creation workshop was held to provide further insight and innovative solutions, as well as to validate key findings, lessons learnt, and formulate recommendations. This data was integrated as part of the evidence. These workshops included internal UNHCR stakeholders only.

Table 4. Data Collection & Sources

DATA COLLECTION & SOURCES	
Document analysis	Internal and external documents were reviewed. (see Annex 3)
Semi structured KIIs	44 individuals interviewed from UNHCR headquarters staff, UNHCR regional and country staff, BMGF representative, partner NGOs and project staff and beneficiaries: 10 UNHCR staff, 25 project staff and partner NGOs, 1 consultant trainer, 3 PHO, and 3 beneficiaries (see Annex 4).
Quantitative coverage	Quantitative data using existing project's monitoring databases, reports of partner NGOs and UNHCR Focus reports
Participatory virtual validation and co-creation workshop	Workshop was conducted on 11 March 2021, with internal UNHCR Public Health Section and Country Office staff.

The evaluation uses an inductive approach to data collection and analysis in order to assess UNHCR's contribution to results. Raw qualitative and quantitative data were explored to derive concepts, themes and trends. Qualitative audio data were coded in MAXQDA data management software. All quantitative data were cleaned, entered and analysed using Microsoft Excel. The process was designed to

systematically and transparently minimize bias and maximize evidence. Despite the development of a pragmatic but systematic approach to collecting and analysing a substantial volume of qualitative and quantitative data, field visits were not feasible due to ongoing Covid-19 restrictions, an important limitation in providing robust insight into the project.

During the evaluation process, the evaluation team adhered to the UNHCR Code of Conduct, UN Ethical Guidelines for Evaluations, and respected UNHCR's confidentiality requirements. As a result, interviews were undertaken upon oral consent, and based on agreement that details would not be attributed to a specific person or agency.

To ensure the quality of results, the evaluation team applied the UNHCR 'Evaluation Quality Assurance' (EQA) guidance. The evaluation team integrated comments from the UNHCR Evaluation Office, the Reference Group, and the Public Health Section. Feedback from the validation workshops and the first draft report were discussed and integrated.

The initial project was funded for 2 years: 2018 and 2019. An extension was granted at the end of 2020, for the period January 2020 until June 2021. The external evaluation was intended to be completed in 2020. Due to the Covid-19 pandemic, the timeline changed. The decision was made to include data from January until September 2020 in this evaluation, since they were available at the time of the data collection and would inform assessment of project sustainability.

Limitations of the evaluation

The evaluation had several limitations. Firstly, the evaluation team was not able to travel to the field locations due to ongoing Covid-19 restrictions. As a result, all Key Informant Interviews (KII) had to be conducted remotely, Focus Group Discussions (FGD) with stakeholders were not conducted, and none of the activities were observed by the evaluation team in person. There was no opportunity to collect sufficient data from POCs. One small FGD was held but since this data was limited it has not been represented in the evidence.

Secondly, there were some problems with completeness and reliability of the primary quantitative data available to the evaluation team. A range of issues have hampered monitoring and evaluation of the project: fluctuating reliability of the variables in the data collection tools, erratic understanding by project participants of some definitions or some indicators, workload of the PHOs and the location of the project manager who was not able to travel regularly to the settings for training and supervision. Limited quantitative data on the activities was provided at community level.

Thirdly, for the period January 2020 until September 2020 (the first nine months of the extension included in this evaluation), the evaluation team only had access to quantitative data from the project's M&E database and a few short narrative reports.

3. Findings and specific analyses

3.1. Design

KEQ 1: To what extent is the 2018-2019 BMGF project design relevant to achieve its intended goal and objectives of saving maternal and newborn lives in refugee camps/settlements in Cameroon, Chad and Niger?

3.1.1. Extent of alignment to population needs and baseline assessment

UNHCR conducted baseline assessments to effectively inform the design of the project in all three countries. The agency implemented robust mixed-method methodology including document review, Key Informant Interviews (Cameroon, 26; Chad, 21; Niger, 15) and Focus Group Discussions (Cameroon, 40; Chad, 48; Niger, 14) including with the participation of populations of concern, with a total of 378 participants in Cameroon, 458 in Chad, and 118 in Niger. UNHCR assessed 33 health facilities (Cameroon, 11; Chad, 15; Niger, 7) with a focus on service availability, readiness (using the Service Availability and Readiness Assessment [SARA] method and Reproductive Health balanced scorecards), quality technical auditing, Health Information System (HIS) data, and Socioeconomic Surveys (SES). All of these were used to extract data. Key informants identified the following limitations during the assessment phase: the shortage of consistent data from partners and health authorities, lack of reliable population-specific health data, and a limited investment in assessing the secondary level of health care in Niger. The baseline analysis and outcomes enabled the development of tailored strategic and program development planning and was perceived particularly useful for country-specific alignment of activities to on-site realities.

Interview respondents affirmed the importance of the baseline assessment, which, they explained, included the engagement of various stakeholders, including target communities, and a site visit observation. The findings were instrumental in identifying the needs at country and site levels. The needs were multiple and high. Infrastructure and resources were lacking, as was appropriate training. For example, existing training was described as more theoretical, and the training model utilized thought to lead to loss of knowledge due to lack of follow-up support. Overall, project needs identified were in the areas of infrastructure and energy, workforce training, newborn care strategies and guidelines, Family Planning (FP), and irregularities in capturing mortality data.

The needs assessment results allowed for adequate alignment of project to population needs, making it highly relevant to local realities. As a key informant expressed, *“The project conception was ‘impeccable’.”* (TC)

In its strategy, UNHCR supported the Ministries of Health in all three countries in strengthening the health system with a focus on: (i) service delivery, (ii) health workforce, and (iii) access to essential medicines.

3.1.2. Alignment with BMGF SRH objectives, level of innovation, implications for resources

The UNHCR SRH program across the three countries is well aligned with BMGF SRH objectives, level of innovation, and implications for resources. The BMGF project emphasizes the expansion of LCHI interventions to address maternal and newborn health. These include the use of the partograph, active management of third stage labour (AMTSL), hygienic cord care, thermal care, initiation of breathing and resuscitation, early initiation of exclusive breastfeeding (EIBF), kangaroo mother care (KMC), training and support of Community Health Workers in conducting pre and post-natal home visits, eye care as well improving access to and acceptability of contraception/family planning and other components of Emergency Obstetric and Neonatal Care (EmONC).

The novel approach of on-site training of health care providers included the use of mannequins for hands-on training and keeping it short and focused on assessed needs, reduced costly off-site capacity development.

3.1.3. Gaps/limitations in the design of the project

Despite sufficient levels of alignment to global and population needs, there were gaps that affected the design of the project. First, investment in the district hospitals was limited due to insufficient funding. Secondly, the cascade-training model required additional time to consolidate learning and cover all subjects, especially since baseline knowledge levels were generally low. Thirdly, given the importance of the CHWs, their role could have been better-defined (guidelines, monitoring data/activity log) and better supported (financially). Local regulations on compensating CHWs made it challenging to incentivize and reward the significant effort of the CHWs. Fourthly, the project did not sufficiently address the lack of access to C-sections. Additionally, focus on family planning was insufficient due to emphasis on the supply side (availability of contraceptives and improving the quality of care) and less on the barriers to demand. General information was provided to women during clinic and home visits, and in some regions on specific target groups (e.g., adolescents in Cameroon); however, addressing important community-level socio-cultural barriers to utilization of family planning was not part of the overall design. In Niger, the existence of the “École des maris” was deemed complementary to the project’s family planning efforts.

3.1.4. Extent of adaptability of the project to contextual factors

The project design’s relevance was further accentuated by some flexibility by country, site and context. Adaptations occurred based on site-level infrastructure needs (e.g., upgrades, additions, construction), security issues and the COVID-19 pandemic. For example, security problems required relocation of refugee sites in Niger. Adaptations in response to COVID-19 included increased Infection Prevention and Control (IPC) measures, triage at health facility entrances, physical distancing, hand hygiene points, and provision of Personal Protective Equipment (PPE) to health staff. As a result of the project design and

flexibility, the pandemic did not affect the overall structure, allowing for adjustments to be made to implementation.

3.2. Implementation

KEQ 2: How successfully have the projects been operationalized? To what extent was the project implementation in each country delivered as intended in the following areas: Capacity building of care providers, Health facility strengthening, Comprehensive maternal and newborn care packages (including low-cost high impact activities), Comprehensive family planning services, Good practices and guidance to improve care.

3.2.1. Capacity development

- Maternal and neonatal health

UNHCR efforts in conducting training using the ‘Helping Mothers Survive (HMS) and Helping Babies Survive (HBS)’ modules and the Low-Dose-High-Frequency (LDHF) pedagogy were an important contribution to the capacity development program objectives. The purpose of capacity development activities was to improve good practices and quality comprehensive maternal and newborn health services, through increasing knowledge and skills in providing quality essential newborn and maternal health care, including Basic Emergency Obstetric and Neonatal Care, among health care staff and to an extent the community. UNHCR invested in a regional technical consultant to conduct quality “training of Master Trainers (MT)” on key topics to health care service providers and supervisory personnel in the selected refugee settings in Chad, Cameroon and Niger. The training followed a specific plan of training “Masters”, nearly all working in the health facilities or with the partner NGOs. They would in turn train their colleague health care providers at their workplace using the LDHF methodology with the training material provided at each site. In all countries the Master trainings started late in 2018, due to delays in reception of the training material (an international order at Laerdal Global Health), resulting in limited time to implement the LDHF modules to all the health care providers within the first phase of the project (2018-2019). Other challenges included the turnover of staff, the departure of some Master Trainers from the project, and the seasonal increase of consultations due to malaria diverting work.

On average, two rounds of master trainings were conducted in each country: one in 2018 and one in 2019. In total, seven trainings of 10-12 days each were conducted by the training consultant, of which two in Cameroon, three in Chad and two in Niger. In 2019, training topics included both a review of key subjects from 2018 as well as the introduction of new modules. Forty-four Master Trainers (MT) successfully completed all the modules foreseen for the master training in 2018-2019. Some participants from the first round of master training in 2018 were no longer working in the relevant settings. MT chosen from regional public health departments who were trained in 2018 in Niger were largely unable to travel to field sites due to high insecurity in the Mali border regions. Due to this problem, in 2019, new MT based permanently in the field locations were selected, reducing the need for travel and the issue of security constraints. In Chad, not all MT enrolled were certified, due to the generally low level of knowledge and skills.

In Cameroon, an additional 10 MT were trained in 2020. Table 5 presents the number of certified MT in each country for the period 2018-2020. The differences in number of MT trained are due to the differences in numbers of health facilities supported, and the inclusion of new facilities in the extension phase.

Table 5. Number of Master Trainers trained

NUMBER OF MASTER TRAINERS HBS/HMS			
	2018	2019	2020
Cameroon	11	11	10
Chad	9	24	0
Niger	9	9	0

Rollout of the low dose high-frequency trainings began in the health facilities at the end of 2018. A total of 997 LDHF sessions were held by the end of 2019 with 2193 health workers participating, and thus, reaching on average, 65% of the relevant health staff. Challenges to motivate staff in the district hospitals in Chad to participate in the LDHF sessions were mentioned, because no monetary incentives had been provided. Other challenges identified to reach 100% trained staff include: high workload, prioritising patient care, and difficulty to assemble all staff at the same time.

A total of 13 subjects were taught using competency-based teaching techniques (Table 6). Each round included a module (with practice) on competency-based teaching and learning, as well as a module on respectful maternity. Training models and material as well as specific educational tools were distributed in all HF.

Table 6. Capacity development modules and training material

CAPACITY DEVELOPMENT MODULES AND TRAINING MATERIAL		
Modules & Content		Training material provided
"Helping Mothers Survive"	Bleeding after birth Pre-eclampsia and Eclampsia	Flip charts, Provider Guides, Posters, Parent Guides NeoNatalie w/ Upright Bag-Mask Penguin Newborn Suction Upright Newborn Bag-Mask Nifty Feeding Cup CarePlus KMC Wrap PreemieNatalie & MamaBreast MamaNatalie Birthing Simulator Mama-U Postpartum Uterus Model
"Helping Babies Survive"	Helping Babies Breathe Essential Care for Every Newborn Essential care for small babies	
Other modules	Normal progression of labour (partograph) Causes of labour dystocia Responding to abnormal foetal heart rates Indications for caesarean section Vacuum extraction Preventing and managing infections Threatened preterm labour Other complications of labour	

The efficient and much appreciated capacity building approach with LDHF sessions continued in 2020 in Cameroon and Chad. In Niger, due to the closing of 2 camps and the departure of some MT, the provision of LDHF sessions stopped. The strategic choice to train staff working in the health facilities as Master Trainers, as well as the provision of a complete set of training material and support tools, made it possible to continue capacity development without costs after the completion of the first phase of the project. Some partner organisations employed midwives as mentors to assist with the follow-up of the LDHF training. **Across the three countries and up to the end of September 2020 the UNHCR LDHF sessions reached 4 352 health care providers, representing 80% of the intended target at onset of the project which was considered very satisfactory.** (Table 7)

Table 7. Low Dose High Frequency Sessions on HMS and HBS 2018-2020

LOW DOSE HIGH FREQUENCY SESSIONS ON HMS AND HBS 2018-2020				
	Nb of Sessions	Participants	Providers	% achieved
2018	8	45	56	80%
Cameroon	1	7	11	64%
Chad	5	25	30	83%
Niger	2	13	15	87%
2019	989	2 148	3 310	65%
Cameroon	431	1 002	1 672	60%
Chad	502	845	1 254	67%
Niger	56	301	384	78%
TOTAL 2018-2019	997	2 193	3 366	65%
<i>2020</i>		<i>2 159</i>	<i>2 064</i>	<i>105%</i>
Cameroon	NA	1 113	737	151%
Chad	NA	1 046	1 327	79%
TOTAL 2018-2020		4 352	5 430	80%

Table 8. Family Planning Training

FAMILY PLANNING TRAINING			
	Number of participants	Total Number of providers	%
2018	218	240	91%
Cameroon	69	69	100%
Chad	49	49	100%
Niger	100	100	100%
2019			
Cameroon	18	29	62%
TOTAL 2018-2019	236	249	95%
<i>2020</i>	<i>193</i>	<i>200</i>	<i>97%</i>
Cameroon	97	61	159%
Chad	96	139	69%
GRAND TOTAL	429	469	92%

- **Family Planning (FP)**

During the baseline assessment, the training needs for FP provision and counselling were evaluated. The baseline assessment found that more than 50% of the staff in the assessed facilities were never trained in FP provision and counselling. Across the two implementation years, 236 staff were trained on Family Planning methods and counselling, covering 95% of the evaluated needs. All the trainings were conducted by national or regional MoH trainers. Another 193 providers were trained in Cameroon and Chad in 2020 (January till September), including staff from outside the target health facilities. (Table 8)

In East Cameroon, extra emphasis was put on Adolescent Sexual and Reproductive Health, including additional staff training and educating youth about contraceptive methods. Due to the limited number of staff at each camp health centre, additional staff from regional health centres and hospitals were invited to attend the training.

- **Capacity building of Community Health Workers**

UNHCR, through its partner NGOs, conducted trainings for 578 community health workers (72% of the initial target), to ensure provision of a continuum of care and link the community to the health facility. A 4-day training course “Visites prénatales et néonatales à domicile” was implemented and most key informants stated that this investment resulted in improved linkage between the target communities and the health facility, and improved referral links. Content and tools were relevant and aligned to the World Health Organization (WHO) *Caring for the Newborn at Home programme* (2012). The training was based on the principles of adult learning and was specifically designed to focus on active and problem-based learning. The trained CHWs were provided with equipment and tools to conduct home visits and assess the mothers and newborns, which improved the visibility and efficacy of their work.

In Cameroon, a total of 223 out of the 368 CHW (60% of target) received training in 2018 and 2019. In Chad, all project sites conducted trainings for a total of 437 CHW (approx. 80% of target) in 2019. In 2018, only 33% of all the CHWs were trained. However, in 2019, 75 additional community health workers (CHW) were recruited and trained, reaching 100% of the set target for those newly recruited CHWs. In all three countries refresher trainings for CHWs were conducted in 2020.

3.2.2. Health facility strengthening

Renovations of health facility structures were pertinent and catalytic in establishing health facility readiness across all three countries. In Cameroon, 6 maternity departments were equipped with solar panels (providing light and sustainable electricity). In Chad, 5 maternity departments received solar panels and other renovation support (roofing, painting and tiling). The maternity units in Iridimi, Touloum and Amnabak health facilities were restored during this project. In Niger, a pharmacy storeroom was transformed into a postnatal care room. To address gaps in transportation for referral, 5 autorickshaws were procured in the Southern region of Chad and increases in a rented horse and cart system were implemented in the East.

In addition to renovation, several health facilities were supported with additional health workers to meet minimum requirements, ensure proper supervision, and to effectively monitor and evaluate

the project's activities. In Cameroon, two experienced midwives were recruited and retrained in the different areas of mother-child health. They were kept as focal points for the 2019 fiscal year to ensure continuous supervision of field activities. In Niger and Chad as well, all health centres had a qualified midwife available 24/7 and in Niger the project recruited SRH focal points in each site, which - according to the key informants – contributed to improved supervision and quality of care.

3.2.3. Comprehensive maternal and neonatal care packages

UNHCR, through the partner NGOs, implemented the project effectively across the three countries through a comprehensive maternal and neonatal care package, establishing effective and timely referral mechanisms to Emergency Obstetric and Neonatal Care (EmONC) services, implementing community-based care, and ensuring reliable supply mechanisms and stocks.

Comprehensive maternal and neonatal care packages have been implemented at all sites. All the health facilities were supplied with the necessary additional equipment and medical material to enable them to provide essential care at birth. The availability and access to EmONC has been ensured through the training and provision of drugs and equipment for Basic Emergency Obstetric and Neonatal Care (BEmONC) – including care for small babies – in all the primary health centres and up to a certain point, Comprehensive Emergency Obstetric and Neonatal care (CEmONC) at selected referral district hospitals in Cameroon and Chad. The implementation and follow-up of the activities as well as the referrals at secondary level were considered more challenging given that partner NGOs were not fully implicated at that level. Additional staffing at the district hospitals was not provided. The training focused on the provision of BEmONC functions that do not include obstetric surgery or blood transfusion. In Niger, only primary health care centres were included in the project due to the fact that the referral hospitals were already well supported by other actors. Referral mechanisms between both levels have been implemented in all countries, including communication and transport means. Combined with increased mothers' awareness of danger signs, staff and beneficiaries report improved timeliness of care-seeking behaviours and access to emergency care at the healthcare centres. One mother elaborates: *"The project has helped us because we now know more; even if we leave to go back home. They go around with the picture cards in their pockets and used them to teach us danger signs; like when a child is hot, or when they are not taking the breast."*(JC)

The analysis of the essential drugs, consumables and material tracker indicated that all sites were broadly speaking well equipped. However, delays in international orders were reported by all three countries, most notably in Chad. Cumbersome internal procedures to access funds and place international orders contributed to stock ruptures.

Cameroon and Niger reached the 90% target of having the 23 essential supplies and equipment⁸ available at any point in time. In Chad, rates ranged from 67% to 89%. The most frequently missing supplies included: hydroalcoholic gel, vacuum extractors, clocks, resuscitation tables with a heating source. Specific to neonatal resuscitation, all health facilities were equipped with a quality bag and mask with high rates of availability in all facilities from January 2019 onwards.

The essential medicines tracker⁹ demonstrates that the target (90% of essential medications for childbirth available in each facility) was only met in Niger in 2 quarters out of 5, and never met in either Cameroon or Chad. Delays in supplies at the start of the project resulting in important stock ruptures including Cefixime, Azithromycin, Methyldopa, Misoprostol and Hydralazine contributed to these results.

The proportion of essential equipment and medication continued at about the same rates in 2020 in both Cameroon and Chad, although funds were not yet available for the extended period of the project. In Niger, rates got close to 100% in 2020. In Cameroon, rates fluctuated between 77% and 96% and in Chad between 72% and 87%. (Table 9)

Table 9: Availability of essential equipment and drugs

ESSENTIAL EQUIPMENT AND MEDICINES										
			2018	2019				2020		
	Baseline	Target	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Percentage of essential equipment for childbirth care available										
Cameroon	80%	90%	86%	96%	95%	93%	92%	92%	96%	95%
Chad	69%	90%	67%	84%	83%	89%	89%	87%	87%	85%
Niger	77%	90%	83%	86%	80%	94%	94%	99%	99%	99%
Percentage of essential medications for childbirth care available										
Cameroon	71%	90%	73%	82%	85%	83%	81%	77%	84%	86%
Chad	68%	90%	67%	81%	69%	88%	79%	86%	75%	72%
Niger	72%	90%	90%	85%	87%	80%	94%	97%	97%	98%

Kangaroo mother care (KMC), an underused practice in the targeted countries, was implemented early in the project and was very well received by both staff and mothers. The capacity building activities to increase knowledge and competencies of the staff to take care of low-birth-weight babies using kangaroo-mother care (KMC) were accompanied by sensitization activities to increase uptake and the provision of material. Kangaroo kits, composed of a wrap (locally made), a cap, a blanket and a towel,

⁸ Examination lamp, Cord clamp, Delivery table, Resuscitation table (with heat source), Bag and face mask for resuscitation of full-term babies, size 1, Bag and face mask for premature babies, size 0, Neonatal airway suction tip, Speculum, Baby weighing scale, Blood pressure monitor, Watch or clock in the delivery room, Fetal stethoscope or Doppler, Clean running water (piped, bucket with tap, or jug with spout), Liquid soap/soap bar for hand washing, Alcohol-based hand cleansing solution

⁹ The following essential medicines were checked for availability on a quarterly basis: Chlorure de sodium injectable, Gentamicine en injection, Ampicilline en poudre pour injection, Benzathine benzylpénicilline, en poudre pour injection, Métronidazole en injection, Azithromycine, Céfixime, Hydralazine injectable, Nifédipine en gélule/comprimé (10mg), Methyldopa en comprimé, Gluconate de calcium, Sulfate de magnésium, Désinfectant pour la peau, Pommade antibiotique ophtalmique pour nouveau-né, Bétaméthasone ou Dexaméthasone (pour le travail prématuré menacé), Vitamine K, Nevirapine (NVP) or Zidovudine (AZT) (pour PTME), Misoprostol, Ocytocine en injection

were available everywhere at all times in Cameroon, but only for 80% of the time in Niger and Chad. Nonetheless, it did not inhibit them from providing KMC with fabric from the mothers. Stakeholders reported a lack of space in some facilities that had a negative impact on intimacy. In Cameroon, a special KMC unit was established in the district hospital of Gara-Bouley responding to the need for additional services to take care of the high number of LBW babies identified during the baseline assessment. The evaluation indicates good KMC acceptance of the mothers.

In addition to the LCHI activities discussed above (KMC and newborn resuscitation), other LCHI activities were also found to have been implemented effectively across all sites and countries including: a qualified midwife available 24/7, Active Management of the Third Stage of Labour (AMTSL), use of partograph, a companion of choice during birth. LCHI activities for newborn care included delayed cord clamping, hygienic cord care, thermal protection, immediate and exclusive breastfeeding and review of neonatal deaths. All these essential newborn practices were implemented with a high rate of success except for the reviews of neonatal deaths, a practice that is not yet systematised

The evaluation found that implementation of the CHW program did not always go as planned. While training was well perceived and pre-post testing satisfactory, there were several barriers resulting in some activities not being implemented. Barriers included budget limitations and delays in supply. Family planning distribution and outreach activities were not implemented in all sites. The objectives of visiting all pregnant women twice during their pregnancy, and mothers and newborns three times during the first week after birth, were not reached everywhere according to the stakeholders interviewed. This could not be confirmed by data. Reasons mentioned for not reaching the set target were delays in training delivery (translation of the module in French had to be done first), the insufficient number of CHW, and the lack of material to conduct visits. Insufficient supervision and shortage of continuous capacity development were also mentioned as challenges.

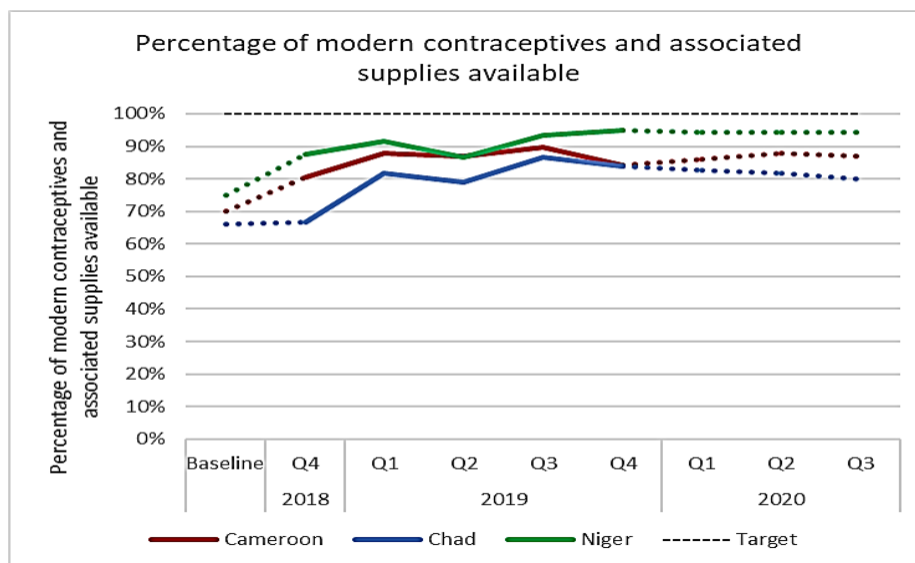
3.2.4. Comprehensive family planning services

The UNHCR project implemented comprehensive family planning activities in all sites across the countries to address both the demand and supply sides. As discussed above, training for all health care providers – and not solely FP staff - aimed at improving skills and counselling quality to improve contraceptive acceptance and use in women as well as men, adolescents, and in the immediate post-partum. CHWs and TBAs were trained on counselling on birth spacing, the different contraceptives available and contraceptive counselling. Mobile clinics to bring quality services to remote communities were only implemented in Cameroon.

UNFPA is the main provider of contraceptive methods in the countries, but stock ruptures were frequent and the project ensured provision, when necessary, in 2019. Although additional orders of modern contraceptives (both short and long-acting methods) were made with the project's budget, none of the countries reached the target of 100% availability of modern contraceptives and associated supplies, but all countries demonstrated improvements compared to the baseline. (Figure 3)

Other actors were involved in family planning, but coordination between the different family planning actors was insufficient.

Figure 3. Percentage of modern contraceptives and supplies available



3.2.5. Good practices and guidance

Good practices and guidance were maintained through continuous supportive supervision and LDHF training, and by making guidelines and flowcharts available to staff. Very early in the project, printing and distribution of protocols and guidelines was undertaken. Tools developed in the BMGF-funded project in Jordan, South Sudan and Kenya have been translated into French. Posters and flipcharts from the HBS and HMS modules are available in all facilities. The new culturally-adapted CHW tools (counselling cards) were also distributed. At the baseline point, only 13% of a standard list of clinical guidelines for Sexual and Reproductive Health (SRH) and HIV were available overall. By the end of 2020, health care facilities had achieved between 94% and 100%. FP guidelines were made available in all facilities achieving rates of 100% availability in Cameroon and Niger and 80% in Chad. (Figures 4 and 5)

The monitoring of the program data seemed robust and well established and was an important contributor to monitoring and informing the programming. A database with more than 180 indicators was established to follow-up and evaluate activities and outcomes and inform the logical framework's output and outcome indicators. Partner NGOs and UNHCR country informants stated that the UNHCR project coordinator appropriately and consistently guided the project teams in all countries.

The use of project data was seen as valuable and an important tool for informed decision-making, the identification of weaknesses in service provision, and to implement better practices. Good practices were shared within each country including through training consultants and WhatsApp groups.

Figure 4: Percentage of clinical SRH and HIV guides available

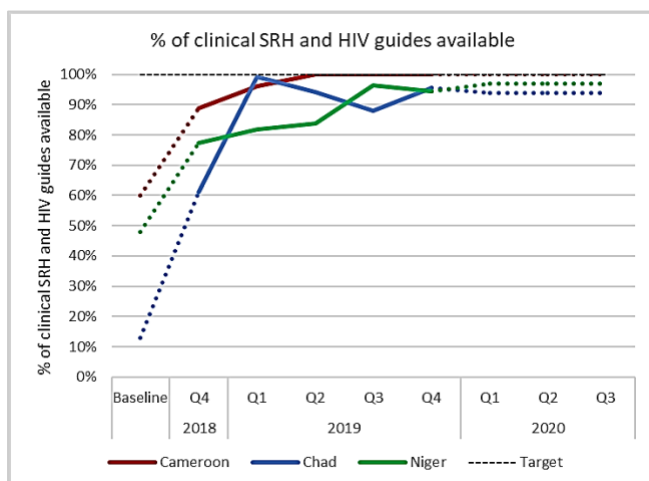
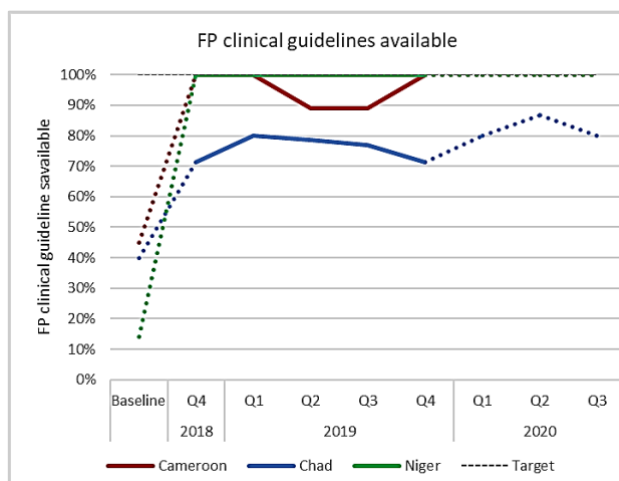


Figure 5: Percentage of FP guidelines available



3.2.6. Major factors influencing project implementation and variations by country

- **Positive Factors:**

The key factors positively influencing the successful implementation of the project were identified as the baseline needs assessment, the project design, adaptability and flexibility, and engagement of multiple partners. The design and organizational set up of the project were based on collaborative assessment of site-based and country-specific infrastructure, training and Maternal and Newborn healthcare needs. The training models of LDHF and the train-the-trainer cascade approach and ongoing support were reported to be ideal for the low-resource settings. Though the design was similar across countries, it was flexible enough to be adapted to variations in need. In Cameroon, for example, project staff and partners procured needed essential drugs and equipment for 3 health facilities through supplemental funding. Adolescent sexual and reproductive training was conducted in East Cameroon, while in the northern sites additional FP outreach activities were conducted. Due to the high rates of prematurity in the East of Cameroon, a special unit devoted to KMC was set up in one of the district hospitals. In Chad, project staff acquired 5 motorbikes for use in emergencies and decided to produce a documentary about the project (currently underway). In Niger, specific mentors were designated at health facilities to provide support throughout the project implementation, and a reproductive health coordination centre was set up at each site.

Project flexibility and adaptability was also evidenced in the adaptation of the timeline for activities at the onset of the COVID-19 pandemic.

Another key factor was the engagement of multiple actors from project onset at baseline assessment through implementation. Partner staff reported that the inclusion of country ministries of health and hospital directors had a positive effect on implementation. UNHCR public health officers were identified as the main drivers of the project, with essential support from local partners and from the HCR project coordinator.

- **Challenging Factors:**

Factors that negatively affected project implementation include internal factors within UNHCR control or influence, and those external to the organisation.

Staffing. Frequent turnover of staff (both within HCR and amongst health partners) and change in implementing health partners resulted in disruption of activities and institutional memory. Similarly, transfers and departure of trained staff at the site-levels somewhat affected implementation.

Delays. There were some delays in implementation that led to an inability to complete the reproductive health survey within 2018, and validity of survey results have been questioned. There were multiple delays in budget disbursement, affecting the start of project activities. Delivery of some supplies and of trainings were delayed and affected project timeline.

Funding. The existing lack of adequate baseline government funding for health services meant MoH priorities were often focused on meeting basic needs rather than implementation of new activities. It was difficult to address major structural constraints in Ministry of Health facilities, poor supply chain, insufficient human resources, and poor infrastructure with needs reaching well beyond the scope of this project. Project funding was insufficient to cover salaries for all the needed MoH healthcare personnel, to engage additional CHWs, and to complete much needed construction and restoration of facilities.

A few items from project materials arrived damaged from shipping, some additional supplies were needed at certain project sites, and district and referral hospitals were under-resourced. As one beneficiary explains: *“Sometimes the health centres don’t have enough medicine, sometimes they do. In the future maybe you could help by giving them more medicine and things they need.”*

Culture. Some socio-cultural factors impeded successful implementation. Persisting community-level stigma towards contraception resulted in low demand for contraception, particularly in Cameroon and Chad. Key informants from Niger highlighted their “École des maris” programme as an important aide in increasing knowledge and improved acceptance of FP. Healthcare providers (from all 3 countries) interviewed identified the persisting low level of respect for women delivering, often resulting in verbal and and/or physical abuse by midwives or other health care providers.

Pandemic. The COVID-19 pandemic caused some temporary interruption, reduction or delays in activities, including supervision, monitoring and support. As a result of population concern over infection, there was an initial avoidance of health centres at the beginning of the pandemic. This reduced as information about the novel virus increased in communities, given that the number of regional and local cases remained low, and as project activities were adapted and resumed (e.g., home visits, awareness-raising activities) with the use of PPE. In Cameroon and Chad, adaptations included renovation of facilities to expand waiting areas to accommodate physical distancing regulations.

Insecurity. Ongoing refugee crises situations diverted some attention from project activities in the western region of Niger. This regional insecurity resulted in the closing of the sites of Tabareybarey and Mangaize in early 2020. Refugee populations were moved to peri-urban areas and now access the health centres of Ouallam and Ayrou.

3.2.7. Main drivers of expenditure and budget prioritization; variations by context

- Alignment of output targets with planned budgets

Financial analysis was conducted only on the high-level financial data provided, as the evaluation team did not have access to more detailed financial information that would have enabled the team to conduct further cost analysis. Moreover, only the initial project budget – and not the extension – is considered in this analysis.

Generally, output targets were met in line with the allocated budget. No major budget gaps were identified. The overall actual expenditures presented in the final report dated 03/04/20 are aligned with the overall original budget presented in the proposal dated 20/10/17.

Although the original proposal narrative mentioned an equal split of the budget between the 3 countries (\$833 333 each, direct expenditures + Division of Programme Support and Management [DPSM] + indirect costs), according to the stakeholders, the budget was divided based on the number of beneficiaries targeted in the countries. This was a logical conclusion of the relative scale of the project by country and by site within each country. Cameroon accounted for 43% of direct expenditure (with 35% of the beneficiaries), Chad 40% (with 56% of the beneficiaries) and Niger 17% (with 9% of the beneficiaries), as presented in Table 10. DPSM costs allocated to HQ are excluded in this analysis in the absence of relevant detailed information to split them accurately between countries.

Although budgets were considered by country stakeholders to be insufficient compared to the needs, funds were disbursed as allocated. Slight modifications were made in each country when needed as some budget lines allowed for local adaptation. BMGF funding was considered important by all stakeholders due to the capacity development focus and the ability to increase capacity at primary health care level to treat complications.

Table 10. Allocated budget and expenditure per country - BMGF 2018 – 2019 \$

ALLOCATED BUDGET AND EXPENDITURES 2018-2019						
BMGF 2018-19 \$	Chad	Cameroun	Niger	DPSM	ACTUAL TOTAL 03/04/20	Budget 20/10/17
Country PH coordination	54 578	73 927	16 947		145 452	145 452
Expert consultants +travel				576 000	576 000	576 000
Medical supplies	165 847	178 140	71 543		415 530	415 530
Newborn kits	47 895	51 445	20 661		120 001	120 001
Training & workshops	75 035	80 597	32 368	120 000	308 000	308 000
UNHCR partners	243 464	261 511	105 025		610 000	610 000
TOTAL	586 819	645 620	246 544	696 000	2 174 983	2 174 983
Indirect cost 15%					326 247	326 247
GRAND TOTAL					2 501 230	2 501 230
% direct expenditures per country	40%	43%	17%			

Cost per beneficiary and delivery

Considering the division of total beneficiary numbers (771 693 in total - Chad 56%, Cameroon 35%, Niger 9% [figure 7]), the average direct cost/ beneficiary varies from \$1.36 in Chad to \$3.57 in Niger (figure 8). DPSM costs are excluded in this analysis as not all costs could be fully attributed to individual countries due to the nature of expenditures such as, for example, the project manager's salary.

Taking into consideration the activity outputs in terms of number of deliveries (15 023 in total in 2018-19; Chad 57%, Cameroon 30%, Niger 13% [figure 9]), the average direct cost/ delivery varies from \$69 in Chad to \$143 in Cameroon (figure 10) which again represents a significant variation. (Table 11)

Table 11. Cost per beneficiary and delivery

COST PER BENEFICIARY AND DELIVERY					
	Chad	Cameroon	Niger	DPSM	TOTAL
TOTAL \$	586 819	645 620	246 544	696 000	2 174 983
Indirect cost 15%					326 247
GRAND TOTAL					2 501 230
% expenditures / country	40%	43%	17%		100%
Beneficiaries pop 2018-19	430 693	272 000	69 000		771 693
	56%	35%	9%		100%
Direct cost / beneficiary\$	1,36	2,37	3,57		
Deliveries 2018-19	8 545	4 526	1 952		15 023
	57%	30%	13%		100%
Direct cost / delivery\$	69	143	126		

Figure 6: Direct expenditure per country 2018-2019

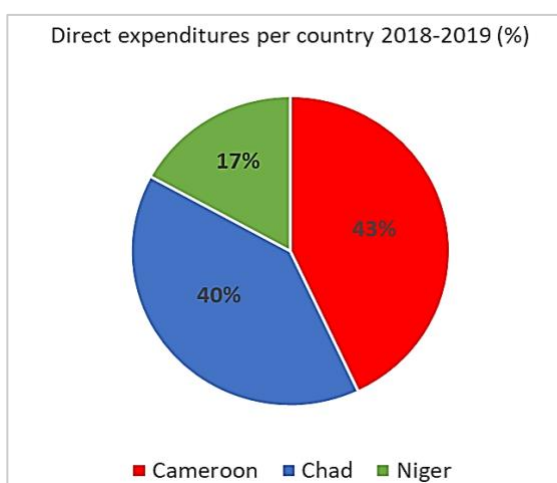


Figure 7: proportion target population

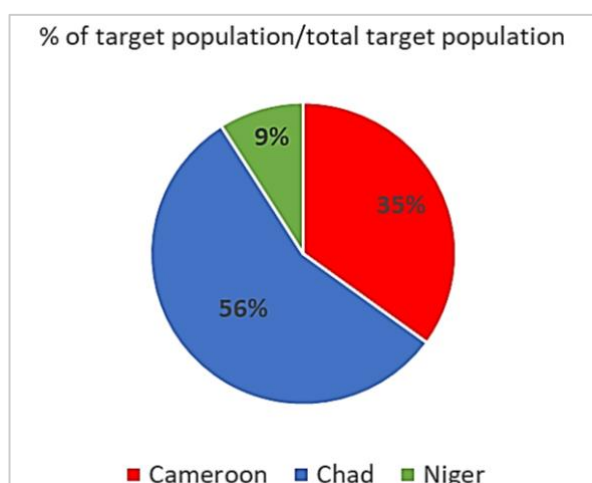


Figure 8: Direct cost per beneficiary (\$)

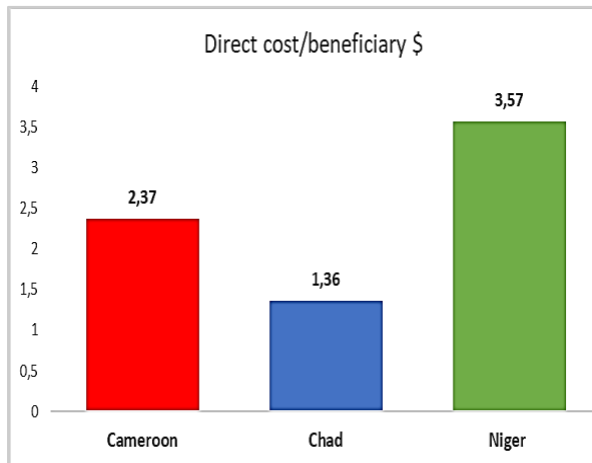


Figure 10: Direct cost per delivery

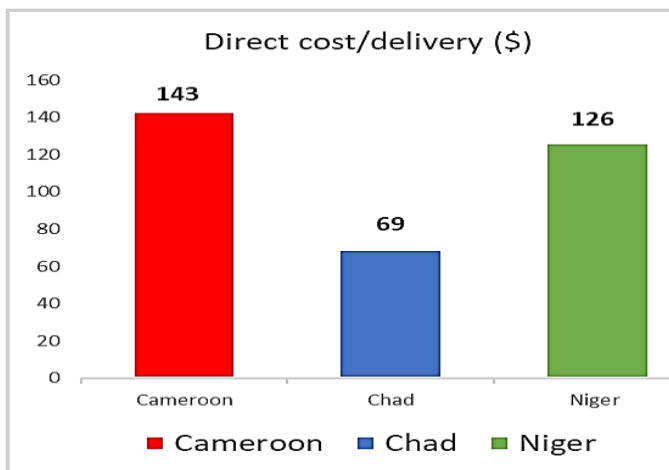


Figure 9: % of deliveries out of total deliveries

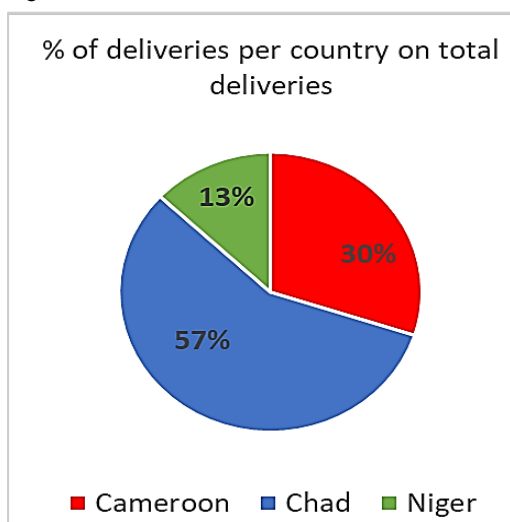
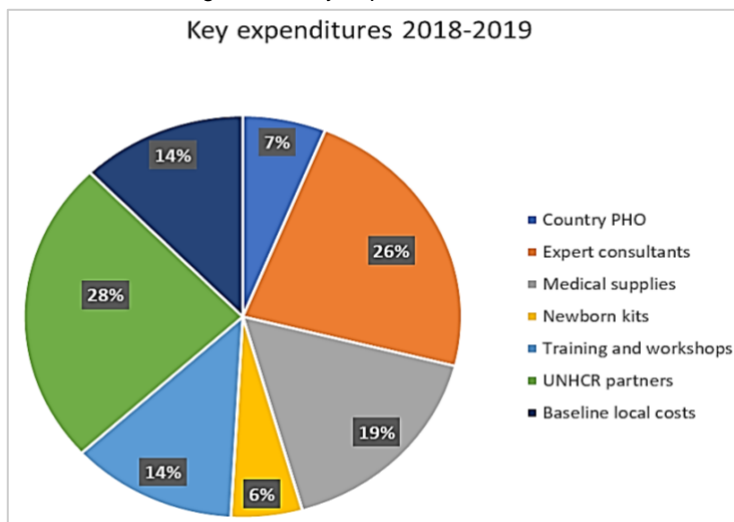


Figure 11: Key expenditures 2018-2019



- **Main drivers of expenditure and budget prioritization; variation by context**

Across the 3 countries, the key expenditures, as presented in figure 11, were:

- UNHCR partner NGOs - 28%;
- Expert project manager, consultants and travel costs - 26% (surveys and trainings);
- Medical supplies - 17% (medical equipment and essential drugs);
- Training and workshops logistics and material - 14%;
- Country public health coordination - 7%;
- Newborn kits - 6%.

If DPSM costs are excluded, the main drivers of costs across the 3 countries were:

- UNHCR partner NGOs - 41-43%;
- Medical supplies - 28-29% (medical equipment and essential drugs);
- Training and workshops logistics and material - 12-13%;

- Country public health coordination - 7-11%;
- Newborn kits - 8%.

Due to insufficient financial detail, the evaluation team's analysis cannot explicitly describe how funding was allocated across UNHCR partner NGO budget lines.

Overall, the split of budget lines for direct expenditures per country indicates alignment with the split of global direct expenditures per country as previously mentioned: Chad 40%, Cameroon 43%, Niger 17%, with a slight difference in country PH coordination where Cameroon spent 51% of the line. (Table 12)

Table 12. Split of budget lines of direct expenditures per country

SPLIT OF BUDGET LINES OF DIRECT EXPENDITURES PER COUNTRY 2018-2019										
	CHAD		CAMEROON		NIGER		DPSM		TOTAL	
country PH coordination	54 578	9%	73 927	11%	16 947	7%		0%	145 452	7%
	38%		51%		12%					
expert consultants + travel		0%		0%		0%	576000	83%	576 000	26%
<i>project manager</i>							220000			
<i>training expert</i>							80 000			
<i>evaluator</i>							50 000			
<i>technical copy editor</i>							20 000			
<i>survey consultant</i>							150000			
<i>expert travel</i>							56 000			
medical supplies	165 847	28%	178 140	28%	71 543	29%		0%	415 530	19%
	40%		43%		17%					
newborn kits	47 895	8%	51 445	8%	20 661	8%		0%	120 001	6%
	40%		43%		17%					
training & workshops	71 842	12%	77 167	12%	30 991	13%	120000	17%	300 000	14%
<i>venue & catering training</i>	47 895		51 445		20 661					
<i>printing/stationery</i>	23 947		25 722		10 330					
<i>training material</i>							90 000			
<i>dissemination workshop</i>							30 000			
	40%		43%		17%					
UNHCR partners	243 464	41%	261 511	41%	105 025	43%		0%	610 000	28%
	40%		43%		17%					
Baseline local costs	3194	1%	3430	1%	1377	1%		0%	8 001	0%
	40%		43%		17%					
TOTAL	586 819	100%	645 620	100%	246 544	100%	696 000	100%	2 174 983	100%
Indirect cost 15%									326 247	
GRAND TOTAL									2 501 230	
% direct expenditures / country (excl. DPSM costs)	40%		43%		17%					

Focus on training costs

To calculate the training costs, it was estimated that 50% of the printing / stationary costs under the training & workshops were related to training; dissemination workshop costs were excluded as not directly related to training. DPSM training costs were split between countries according to the number of health centres trained.

Table 13 displays average full costs per Health Centre trained of \$11 338, with variations from \$10 190 in Chad to \$13 304 in Cameroon. However, when considering the number of staff trained globally (Master Trainers, LDHF/FP, CHW, FP), the average cost per staff trained is \$108, with variations from \$90 in Cameroon to \$132 in Chad, as comparatively, fewer staff were trained during the period under review.

Table 13. Training costs 2018 – 2019 \$

TRAINING EXPENDITURES - 2018-19 \$					
	Chad	Cameroon	Niger	DPSM	TOTAL
Training expert + travel				88 800	88 800
Training & workshops	59 869	64 306	25 826	90 000	240 001
TOTAL	59 869	64 306	25 826	178 800	328 801
% expenditure / country	18%	20%	8%	54%	100%
split DPSM costs/number health facilities trained 2018-19	92 976	55 428	30 396		
TOTAL	1152 845	119 734	56 222		328 801
% expenditure / country	46%	36%	17%		100%
Number of HC trained 2018-19	15	9	5		29
	52%	31%	17%		100%
Cost / HC trained\$	10 190	13 304	11 244		11 338
# of Master Trainers trained 2018-19	25	11	8		44
	57%	25%	18%		100%
Number of staff trained 2018-19 (Master Trainers, LDHF/FP, CHW, FP)	1 161	1 330	557		3 048
	38%	44%	18%		100%
Direct cost / staff trained 2018-19\$	132	90	101		108

A relatively high proportion of the training costs went into the provision of training material ordered through the non-profit organisation Laerdal Global Health, as well as into translating some modules into French. Both of these were a one-time sustainable investment. Employing one regional experienced trainer to conduct all the trainings was considered efficient. He conducted seven rounds overall, training 44 Master Trainers for 29 health facilities, who in their turn conducted LDHF sessions in their assigned facility. Cascaded LDHF trainings have negligible costs if the Master Trainers are staff from the health facilities. (Table 13)

3.3. Results/Performance

KEQ 4: To what extent did the project reduce neonatal and maternal mortality and morbidity and what were the major factors that influenced changes in mortality and morbidity in targeted populations?

Due to cancellation of the field visit, the evaluation incorporates limited robust data informing health care quality. The evaluation has therefore placed more emphasis on the quantitative analysis in demonstrating performance and results. Moreover, the contribution to some of the outcomes lacks maximised evidence, which will be further discussed in section 3.3.2 and 3.3.3. The results framework indicators and additional figures are presented by country in Annex 6.

The evaluation team had access to secondary data through the monitoring and evaluation system in place, and to brief narratives from the partner NGOs.

3.3.1. Neonatal health

- Neonatal mortality

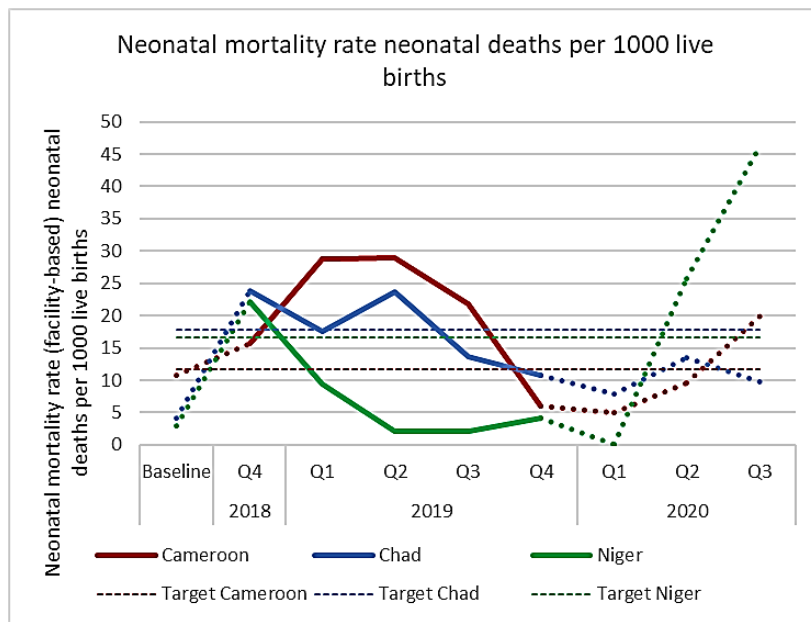
The health worker trainings, in particular LCHI activities, and the overall consistent supply of essential equipment and commodities were reported to be key drivers in decreasing Neonatal Mortality Rates (NMR) to the set target of a 25% reduction in the three countries during 2018 and 2019. The overall (weighted) NMR went from 20.4/1 000 live births in Q4 of 2018 to 14.2 in Q3 of 2019, to a rate as low as 8.5 by the end of 2019. The decreasing trend is noticed in all three countries. In Cameroon, the decreasing trend in NMR continues in the first half of 2020, but increases again starting July 2020. In Chad, the NMR remains under the set target throughout 2020. Data from Niger and Cameroon in 2020 show an increasing trend starting April 2020. Despite these positive trends, results must be interpreted with caution since the low number of births are affecting the confidence interval of the NMR rates.¹⁰ In Niger, the numbers are very small, especially in 2020, following the closure of 2 out of 5 camps (Table 14 and figure 12).

Table 14. Neonatal mortality rates per 1000 live births by country, 2018-2020

NEONATAL MORTALITY RATES PER 1000 LIVE BIRTHS BY COUNTRY, 2018-2020									
	Target (25% decrease)	2018	2019				2020		
		Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
Cameroon	11.7	15.6	28.8	28.9	21.9	6.1	4.9	9.6	19.9
Chad	17.9	23.8	17.6	23.7	13.7	10.8	7.9	13.5	9.8
Niger	16.6	22.2	9.4	2.1	2.1	4.2	0.0	25.8	46.2

¹⁰ This indicator is usually used at national levels or over a longer period of time to be able to measure change

Figure 12. Neonatal mortality rates per 1 000 live births



The different stakeholders question the accuracy of the baseline NMR data which came from UNHCR's HIS data, which showed very low NMR in each setting. Underreporting of neonatal deaths is likely to contribute to the low numbers. The project placed repeated emphasis on the importance of capturing and reporting of all neonatal deaths, which may have increased the accuracy of reporting.¹¹ The data from Q4 in 2018 were therefore used as the baseline for each country. An extensive monitoring system had been put in place during the project, it can therefore be presumed that these are the more accurate NMR.

LCHI activities for newborn care included delayed cord clamping, hygienic cord care, thermal protection (immediate skin-to-skin with the mother after birth for at least two hours), immediate and exclusive breastfeeding and review of neonatal deaths. All these essential newborn practices were implemented with a high rate of success, except for the reviews of neonatal deaths. The availability of bag and masks, increased skills in neonatal resuscitation, the implementation and uptake of KMC and care for sick newborns also contributed to the decrease in neonatal deaths.

Stratified by weight groups, the same decrease in NMR has been found, suggesting that care for low-birth-weight babies has improved as well. Training of the Master Trainers and cascade training of all providers using the LDHF methodology was implemented during the first phase of the project. Not all providers were trained in neonatal resuscitation and essential care for all newborns by the end of 2019, given the different constraints such as availability of training material, high workload and the short implementation time for capacity development. Nevertheless, LDHF sessions continued in Cameroon and Chad during the project extension in 2020.

¹¹ Records and registrations of all births, stillbirths, neonatal, and maternal deaths in a health facility substantially increase data availability. Improved data alone will not save lives but provide a way to target interventions to reduce NMR and stillbirths.

Neonatal death reviews were not conducted in most of the health facilities. Overall, only 17% of the facilities responded positively to the question whether they conducted neonatal death reviews by the end of 2019. This rate is the same as at the start of the project. Neonatal death review rates are very low in each country, even seeing decreasing rates in Niger (from 23% to 13%). Nor did many facilities conduct neonatal death reviews in 2020.

- **Stillbirths**

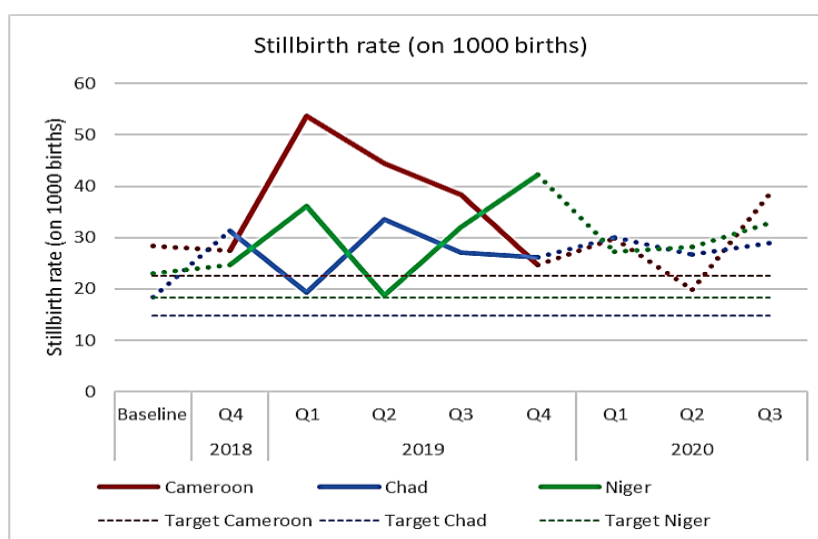
In total, 26 283 babies were born between October 2018 (start of the data collection) and September 2020 in all the sites, of which 3% were stillbirths (SB) (Table 20 and Figure 9).

Stillbirth rates (SBR) were not available before the project started and therefore the SBR from Q4 in 2018 were used to set the target. The target set was a decrease of 20% by the end of 2019. Considering that between 2000 and 2015 the annual decline in SBR was 0,4 % in Niger, 0,2% in Chad and 1,4% in Cameroun¹², the target set was probably very ambitious considering the short project time.¹³ Moreover, as a population-based indicator, SBR rates for a relatively small number of births will fluctuate. None of the countries reached the target set except Niger in Q2 of 2019 and Cameroun in Q2 of 2020, as shown in figure 13. More time is needed to see the effect of the implemented activities to improve timely access to obstetric care as well as quality intra-partum care (the main drivers in reducing SB).

Table 15. Number of births

NUMBER OF BIRTHS									
	2018	2019				2020			TOTAL
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	
Cameroon	1 385	950	833	913	1 016	836	955	938	7 826
Chad	1 821	1 449	1 967	1 877	2 098	2 096	2 057	2 000	15 365
Niger	324	221	477	498	497	329	319	427	3 092
TOTAL	3 530	2 620	3 277	3 288	3 611	3 261	3 331	3 365	26 283

Figure 13. Stillbirth rate



¹² Healthy Newborn Network, <https://www.healthynewbornnetwork.org/numbers/>

¹³ In 2014, the World Health Assembly endorsed a target of 12 or fewer stillbirths per 1000 births in every country by 2030

Figure 14. Neonatal admissions in all countries 2018-2020

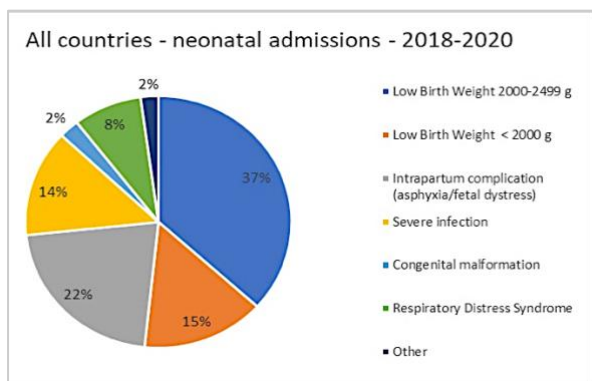


Figure 15: Neonatal admissions Cameroun

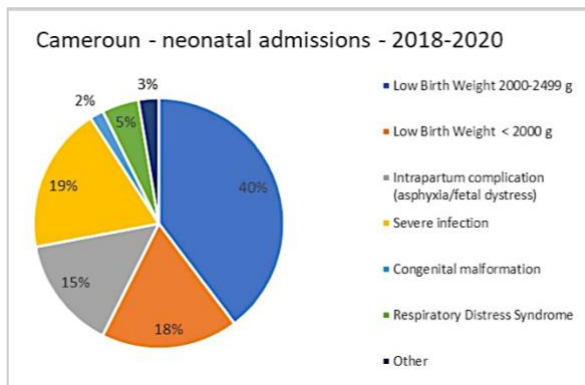


Figure 16: Neonatal admissions Chad

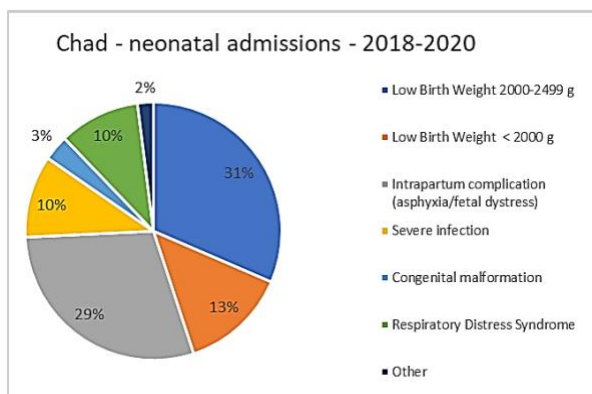
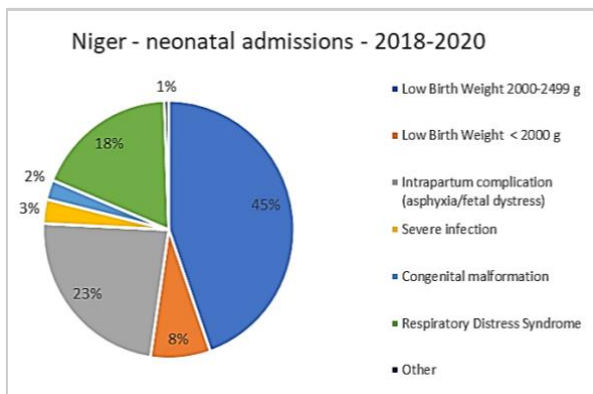


Figure 17: Neonatal admissions Niger



- Neonatal complications

The project collected data on neonatal complications and neonatal deaths due to those complications. Out of 25 479 babies born alive between October 2018 and September 2020, 3 716 (14.6%) were admitted to hospital with a neonatal complication across the three countries. With 52%, LBW was the main complication overall, with 17% having a very LBW (< 2000 g) and 37% a birth weight between 2000 and 2499 g. Of the newborns, 22% had asphyxia and 14% had a severe neonatal infection. (Figures 14, 15 and 16)

The overall neonatal complication rate was very high in Cameroon, potentially due to the overall high rate of LBW babies. In Chad, at primary health care level, between 6-10% of the newborns were admitted with a complication, while at the district hospitals the range was between 0 and 21% - although some data was missing for some hospitals. In the primary health care facilities in Niger, the rate varied from 2 to 23%. None of the countries indicates a decreasing trend. (Figure 18)

- Neonatal case fatality rate

All three countries managed to decrease in the case fatality rate (CFR) from neonatal complications over the course of the first phase of the project. (Figure 19) Chad and Niger had higher CFR for neonatal complications than Cameroon at the start of the project. The steep increase in Niger should be interpreted with caution and is mostly due to the small sample size of both births and complications and the lack of data from the referral hospitals. Data is also required over a longer time period to make conclusions about

trends in CFR. The decrease in CFR is noticed in both LBW babies and babies with a normal birth weight. The evaluation recommends this data be interpreted with caution, because the deaths are calculated based on the complication diagnosed at admission and not the final diagnosis at exit.

Figure 18. Neonatal complication rate

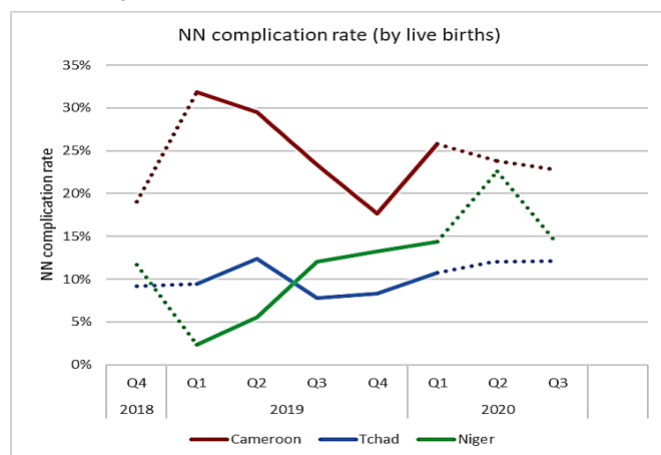
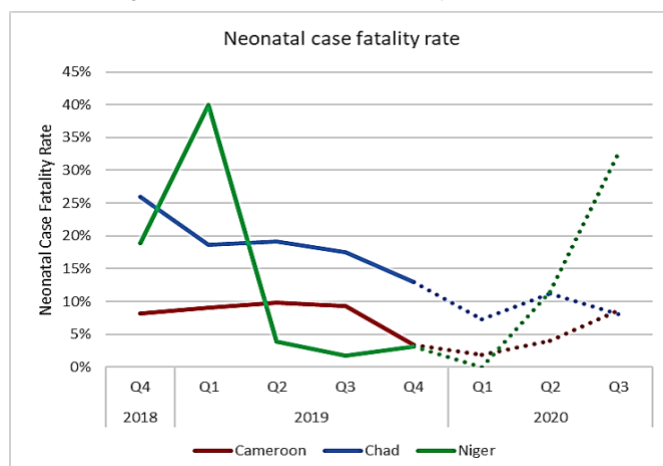


Figure 19. Neonatal case fatality rate



The analysis suggests that the provision and the quality of comprehensive neonatal care, from neonatal resuscitation to caring for small and sick babies, improved in all three countries. In Chad the reduction of neonatal mortality due to complications continued to decrease in 2020. However, in Cameroon and Niger this trend is not noted in 2020. Table 16 summarises the number of newborns with a complication and the CFR by country and by quarter.

In **Cameroon**, 1 795 newborns were diagnosed with a complication between the period October 2018 to September 2020. The mortality in that group went from 8.2% in the last quarter of 2018 to 3.4% at the end of 2019. The decreasing trend in CFR is noticed in all the weight groups, except in the babies weighing < 2000g, where mortality goes up until the end of 2019 before decreasing. Data from 2020 indicates that this decreasing trend in CFR in all weight groups continues up to the 3rd quarter, when it rises again up to levels similar to the start of the project for all weight groups, except babies between 2000-2499g (Table 17).

Table 17. Case fatality rates by weight group in Cameroon

CAMEROON - CASE FATALITY RATES BY WEIGHT GROUP								
	2018	2019				2020		
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
CFR (all)	8.2%	9.0%	9.8%	9.4%	3.4%	1.9%	4.0%	8.7%
CFR > 2 499 g	18%	11%	10%	10%	5%	3%	5%	16%
CFR 2 000 – 2 499 g	2.8%	3.4%	2.6%	2.4%	0%	1.1%	1.7%	0%
CFR < 2000 g	8.3%	17.9%	18.3%	22%	6.9%	0%	3.4%	8.6%

In **Chad** the CFR rate for newborns with complications was very high at the start of the project. Nearly 26% of the 162 babies with a neonatal complication died. The CFR decreased by 50% by the end of 2019: 12.9% of the 170 babies with a complication did not survive. This trend continued in 2020, with a neonatal

CFR of 8.1% at the end of the third quarter (on 235 babies with a complication). Stratified by weight group, the decrease in mortality is especially seen in the newborns weighing > 2500g, to a lesser extent in the LBW babies. The CFR in the very LBW babies fluctuate between 5% and 73.3%. (Table 18) Due to the small sample size of this group, it is difficult to observe statistically significant trends.

Table 18. Case fatality rates by weight group in Chad

CHAD - CASE FATALITY RATES BY WEIGHT GROUP								
	2018	2019				2020		
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
CFR (all)	25.9%	18.7%	19.1%	17.5%	12.9%	7.3%	11.2%	8.1%
CFR > 2 499 g	21%	16%	20%	14%	14%	9%	9%	12%
CFR 2 000 – 2 499 g	10.9%	6.5%	8.7%	27.5%	3.6%	7.7%	8.6%	2.5%
CFR < 2000 g	50%	73.3%	44.1%	13.8%	33.3%	5%	26.9%	13.2%

In **Niger**, 189 babies had a neonatal complication in 2018-2019 and another 174 in the first 3 quarters of 2020. The denominators are too small to demonstrate significant results at the level of the specific CFR. The overall CFR for 2018-2019 is 13.5% and for 2020 14.7% (Table 19).

Table 19. Case fatality rates by weight group in Niger

NIGER - CASE FATALITY RATES BY WEIGHT GROUP								
	2018	2019				2020		
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3
CFR (all)	18.9%	40.0%	3.8%	1.7%	3.2%	0.0%	11.4%	32.8%
CFR > 2 499 g	4%	33%	0%	0%	13%	0%	16%	50%
CFR 2 000 – 2 499g	36.4%	NA	7.7%	0.0%	0%	0%	5%	5%
CFR < 2000 g	100%	50%	0%	20,0%	0%	0%	0%	25%

Very low birth weight babies were cared for with KMC. By the end of the project, nearly all babies weighing less than 2000 g were placed in KMC with their mother or another caretaker. This is way above the target of 60% that was set. During the first phase of the project (2018-2019), 100% of the targeted staff (25 out of 25) were trained in “Essential care for small newborns” in Niger, compared to 58% (125 out of 217) in Cameroon and 63% (100 out of 160 providers) in Chad. Nevertheless, the LDHF data from 2020 show an increase in providers that have been trained in KMC in Cameroon, which most certainly impacted the increasing proportion of very LBW babies cared for with KMC. The nearly continuous availability of kangaroo kits and essential drugs and commodities for small newborns contributed to this positive result. Lack of permanent staff for the Kangaroo mother service and the very small maternity units in some health facilities were mentioned as barriers to providing quality care to very LBW babies.

In **Cameroon**, KMC provision by the health facilities increased from 60% at the baseline to 100% at the end of 2019. In **Chad**, only 41% of the health facilities used KMC for very LBW babies in early 2018. The practice improved to 100% at the end of the first phase of the project. In **Niger**, the same positive uptake

of this LCHI practice can be observed: 100% of the supported facilities provide KMC, compared to 43% at the baseline. The practice continued to be implemented in 2020 at high rates.

Different challenges were encountered that affected the quality and utilisation of maternal and neonatal health services, impacting neonatal health outcomes. Insufficient essential drugs at certain times, under-utilisation of the vacuum extractor, lack of a building reserved only for LBW babies, insufficient specialised staff at some of the referral hospitals for the management of emergencies, the population's low understanding of the risks linked to late referrals, and security problems, were all mentioned as challenges that contributed to less than optimal outcomes.

3.3.2. Maternal health

The UNHCR project contributes to improved maternal health through ensuring the provision of all commodities, training of staff to conduct normal deliveries and provide essential care during labour and birth, ensuring BEmONC at primary health care levels, training CHW to improve uptake of services and linking the community with the health facility, and improving referral mechanisms and transport. In addition, structures were restored where necessary and electricity and water ensured if not available. At baseline, clinical guidelines were not available in nearly all the facilities nor was training material. As discussed above, availability of guidelines reached up to 100% during the project and all 29 facilities received training material for the LDHF sessions. CEmONC was provided at the district hospitals but not fully supported by the partner NGOs; however, the referral system was improved. In Niger, the project did not include facilities providing CEmONC.

Across the three countries, nearly 25 000 refugees delivered in one of the 29 health facilities supported by the project over a 2 year period, of which 7 232 in Cameroon, 14 710 in Chad and 3 012 in Niger. (Table 20) A detailed table with deliveries by health facility can be found in Annex 7. Only in Niger does the timeline demonstrate an increasing uptake of deliveries at health facility level, however institutional delivery rates were high before the project started. On average, in 2017, there were 94% of births in Cameroon sites attended by skilled personnel, 62% in Niger; and 90% in Chad ¹⁴. Data on institutional delivery rates throughout the project by site were not available, but according to all the stakeholders nearly no women delivered at home.

Qualified midwives were available in all settings to provide **LCHI essential care practices at birth**. Nevertheless, in some settings, TBAs continued to provide essential obstetric care. The availability of most of the essential equipment (on average at the end of Q3 2020: 95% in Cameroon, 85% in Chad and 99% in Niger) as well as the high availability of clinical protocols and guideline (ranging from 88% in Chad to 100% in Cameroon) enabled them to provide essential care during labour and birth, using the partograph and actively managing the third stage of labour, amongst other forms of care. Some drugs were missing at certain points in time, which might have impacted emergency obstetric care, but not routine essential

¹⁴ Source: Baseline assessment report 2018, data retrieved in Focus

care at birth. Respectful maternity care and the possibility for women in labour to choose a companion at birth was emphasized during the project.

According to the data, nearly all women in all countries were given the opportunity to be accompanied by a person of choice. Respectful maternity care was a subject included in the Master Trainings; however, the data on how this was tackled during the LDHF sessions is not available.

Table 20. Deliveries by health facility, Cameroon, Niger and Chad, 2018-2020

NUMBER OF DELIVERIES CAMEROON, NIGER AND CHAD									
	2018	2019				2020			TOTAL
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	
Cameroon	1 150	616	853	906	1 001	831	949	926	7 232
Chad	1 817	1 398	1 835	1 524	1 971	2 145	2 046	1 974	14 710
Niger	299	221	469	473	490	324	315	421	3 012
GRAND TOTAL	3 266	2 235	3 157	2 903	3 462	3 300	3 310	3 321	24 954

- **Basic Emergency Obstetric Care**

The UNHCR project aimed at upgrading all the health facilities to BEmONC centres. To ensure accessibility, the project was designed in a way that all health facilities were upgraded to BEmONC centres. The baseline assessment identified the main barriers to providing all seven BEmONC signal functions: lack of newborn resuscitation equipment; lack of knowledge in newborn resuscitation; and lack of assisted delivery using a vacuum due to lack of equipment, lack of knowledge, or both. The baseline assessment found that the majority of childbirth providers have not benefitted from recent training in routine or emergency obstetric and neonatal care, and gaps in skills and knowledge were numerous. **The target of performing at least six (6) out of seven (7) signal BEmONC functions¹⁵ in each quarter was never reached in any of the countries.** Reasons for non-performance of some signal functions were two-fold. On the one hand, there was a delay in the supply of vacuum extractors, causing delays in providing training and making the manoeuvre impossible (1 out of 7 signal functions for BEmONC). On the other hand, the low caseload in the different health structures is such that not all complications were encountered every trimester in every health structure. Except for the vacuum extraction, additional data analysis confirms that all the other signal BEmONC functions were performed regularly, ranging from 78% to 100%, depending on the facility. To ensure staff remained competent and skilled, even without having the cases, the project ensured training material and flowcharts/posters as well as at least 1 Master trainer available in each site to conduct the LDHF sessions to their colleagues. In 2020 the number of training modules in vacuum

¹⁵ 1. Administer parental antibiotics, 2. Administer uterotonic drugs, 3. Administer parental anticonvulsants for pre-eclampsia/eclampsia, 4. Assisted vaginal delivery (vacuum extraction), 5. Manual removal of retained placenta, 6. Removal of retained products of conception (e.g. manual vacuum aspiration), 7. Neonatal resuscitation (with bag and mask)

extraction increased in Chad and Cameroon, but the unavailability of a vacuum extractor continued to be a barrier for performing assisted vaginal deliveries.

- **Obstetric complications**

Out of a total of 24 954 deliveries, 2 915 (12%) women had a direct obstetric complication. Across the project, in all sites, the maternal direct obstetric complication rate ranged between 4% and 22% with – for obvious reasons – higher rates at the district hospitals. On average, between 10 and 15% of all the women who delivered were treated for a major obstetric complication. This is in line with normal expected complication rates and are indicative of good access to facilities.¹⁶

The main direct complication was obstructed/prolonged labour (38.8%), followed by postpartum haemorrhage (23.2%). Antepartum haemorrhage and severe pre-eclampsia/eclampsia both accounted for nearly 10% of the complications (Table 21).

In **Cameroon**, 993 women (14%) had an obstetric complication, out of 7 235. Nearly 40% experienced a prolonged or obstructed labour, 30% had a postpartum haemorrhage, and severe pre-eclampsia/eclampsia accounted for more than 8% of complications.

Of 14 710 women in **Chad**, 1 624 experienced a direct obstetric complication. This gives a direct complication rate of 11%. As in Cameroon, the majority had an obstructed or prolonged labour, followed by postpartum haemorrhage and abortion-related complications.

In **Niger**, 298 women had a direct obstetric complication (out of 3 012 women). As with the other countries, obstructed/prolonged labour proved to be the leading complication (36.9%), followed by severe pre-eclampsia/eclampsia (29.5%) and postpartum haemorrhage (14.1%).

At the primary health care level, the complication rates were as follows: 8% in Cameroon, 7% in Chad and 9% in Niger. The complication rate was much higher at the referral hospitals, where a large proportion of patients were referred for either management of complications or risk factors identified during pregnancy and labour. Timely access to treatment was not recorded.¹⁷

- **Comprehensive Emergency Obstetric Care**

The C-section rate amongst all refugees that delivered in a health facility ranged from 2.2% in Chad to 3.1% in Cameroon. It was only in the East of Cameroon that the partner NGO was fully involved in the district hospitals. In the other sites in Cameroon and in Chad, basic support was given. In Niger, the project only supported primary health care facilities.

In **Cameroon**, 3 district hospitals conduct caesarean sections and a total of 221 C-sections were conducted on a total of 7 232 deliveries resulting in a C-section rate of 3.1%. 192 blood transfusions were administered over 2018-2020.

¹⁶ Around 15% of all pregnant women will develop a potentially life-threatening complication that calls for skilled care, and some will require a major obstetrical intervention to survive.

¹⁷ The purpose of this indicator is to provide a measure of the quality of maternity care, because maternal mortality is directly related to the effectiveness and timelines of treatment for emergency complications

In **Chad**, 14 710 women delivered, of whom 200 by C-section in one of the five district hospitals, giving a C-section rate of 2.2%. 258 women received a blood transfusion. Data on blood transfusion – amongst other data – were not always reported by the district hospitals in Chad. The district hospitals in Chad were not fully supported by the partner NGOs.

There was no data on referral to CEmONC facilities for **Niger**, mostly due to the lack of support provided to the referral hospitals.

Overall, the C-section rates are lower than the international recommended C-section rate of 5-15%. It is notable that 17% of the data was missing from the 8 district hospitals, therefore actual rates may be higher.

Table 21: Maternal complications: Maternal complications

Maternal complications – Cameroun, Niger, Chad										
	2018	2019				2020			Total	
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3		
Postnatal haemorrhage	53	76	119	74	92	82	89	92	677	23,2%
Antepartum haemorrhage	20	43	40	19	64	38	29	26	279	9,6%
Obstructed or prolonged labour	168	78	166	106	168	160	134	152	1132	38,8%
Uterine rupture	1	4	12	13	5	5	2	2	44	1,5%
Sepsis	2	7	5	5	9	2	10	13	53	1,8%
Severe pre-eclampsia or eclampsia	22	13	40	48	40	28	52	32	275	9,4%
Abortion complications (with haemorrhage or sepsis)	32	15	66	27	15	42	31	28	256	8,8%
Ectopic pregnancy	4	3	2	0	1	2	3	2	17	0,6%
Other	18	15	26	11	48	15	23	26	182	6,2%
Total complications	320	254	476	303	442	374	373	373	2915	100,0%
Deliveries	3266	2235	3157	2903	3462	3300	3310	3321	24954	
Obstetric complication rate %	10%	11%	15%	10%	13%	11%	11%	11%	12%	

- **Maternal Mortality**

The evaluation attempted to analyse maternal deaths and rates, but the small sample size is a limitation to providing robust evidence. The following maternal deaths were reported at health facility level during 2018-2020: 13 in Cameroon (in the nine HF out of 7 232 deliveries), 26 in Chad (in 15 HF out of 14 710 deliveries) and four in Niger (in the seven HF out of 3 012 deliveries). (Figure 20 and 21) The numbers of deliveries were found to be too low to provide any evidence. Additionally, comparisons with the baseline assessment is statistically not appropriate since it provides data on maternal deaths for the preceding three (3) months. Consequently, it would be inaccurate to draw conclusions on observed trends on the number of maternal deaths.

The main causes of maternal death for all countries compiled were septicaemia (24%) and Post-partum haemorrhage (20%), followed by Pre-Eclampsia (PE) and Eclampsia (16%) and abortion-related complications (16%) (Figure 22). In Cameroon, septicaemia was the leading cause of death. Severe pre-eclampsia and eclampsia killed as many women as PP haemorrhage. Septicaemia, PP haemorrhage and abortion-related complications all accounted for 21% of maternal deaths in Chad. In Niger, only 1 mother died during the course of the project. The cause of death was eclampsia.

Figure 20. Total number of maternal deaths

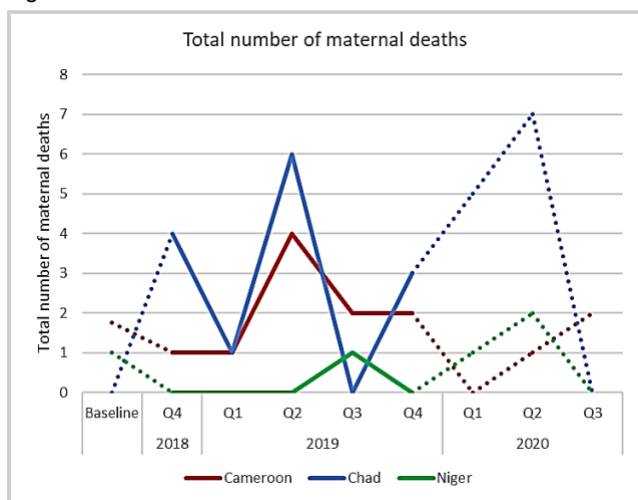


Figure 21. Maternal deaths 2018-2020

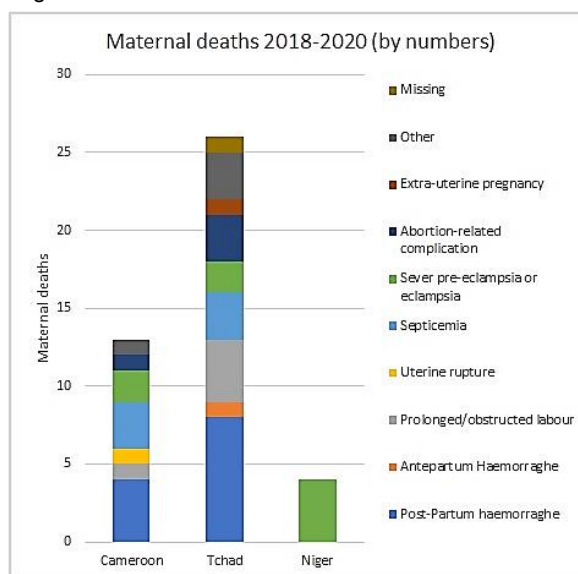
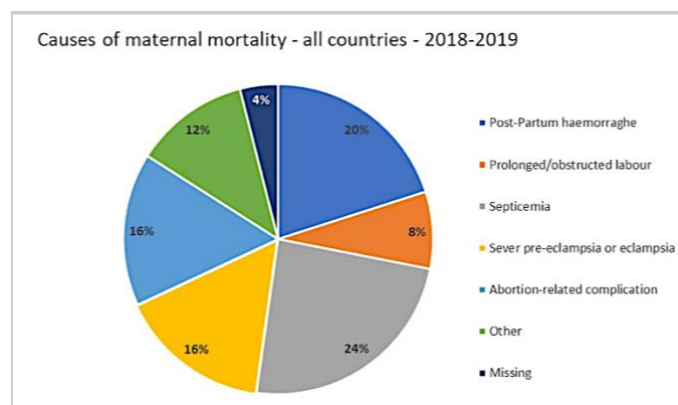


Figure 22. Causes of maternal deaths (%)



The direct obstetric case fatality rate¹⁸, considered a quality indicator at facility level, falls between 1.2% in Cameroon and Niger and 1.4% in Chad over the period of the evaluation (Table 22). As there is no baseline, it is not possible to accurately determine whether the CFR increased or decreased. Nonetheless, these are acceptable rates in an emergency context. Additionally, the number of deaths and direct obstetric case fatality rates may increase when efforts are made to improve hospital services and as more women look for treatment, as in this project. The international agreed standard of quality is a direct obstetric CFR lower than 1%¹⁹.

¹⁸ Total deaths due to a direct obstetric complication/total direct obstetric complications in a given period

¹⁹ The maximum acceptable level for the value of this indicator is less than 1 percent. Studies in low-income countries have shown direct obstetric case fatality rates ranging from approximately 2 to 10 percent, whereas an analysis applying EmOC indicators to data from the United States showed a direct obstetric case fatality rate of 0.06 percent (Lobis et al., 2005). Given this range and results from evaluations of safe motherhood interventions demonstrating that it is possible to reduce a high rate to below 1 percent, the 1 percent cut-off appears to be a reasonable maximum acceptable level for low-income countries (WHO et al., 2010). https://www.measureevaluation.org/prh/rh_indicators/womens-health/sm/direct-obstetric-case-fatality-rate

Table 22. Maternal direct obstetric CFR

MATERNAL DIRECT OBSTETRIC CFR								
	2018	2019				2020		
Cameroon	0.6%	0.7%	3.0%	0.8%	1.8%	0.0%	0.8%	1.7%
Niger	0.0%	0.0%	0.0%	2.4%	0.0%	3.1%	4.3%	0.0%
Chad	2,7%	0,9%	1,1%	0,0%	1,1%	1,6%	3,5%	0,0%

3.3.3. Family Planning Utilisation

The third primary outcome of the project was the improvement of quality comprehensive family planning (FP) services with an expected increase in Contraceptive Prevalence Rates (CPR) and an increase of 20% of new users of modern contraceptive methods. Broadly speaking, the FP activities and goals were relevant, however monitoring and evaluating the contraceptive prevalence rates (CPR) to measure the success of the FP activities presented some challenges. The CPR appeared to be miscalculated in the HIS and was therefore not used as a baseline. Surveys on CPR were also not conducted. As a result, the impact of the FP activities implemented was measured through the number of new users of a modern contraceptive method. Because there was no baseline available for the number of new users of a contraceptive method, data from the fourth quarter of 2018 was used as a baseline. Niger and Cameroon reached the target set of 20% increase in new users of modern contraceptive methods by the end of 2019. (Figure 23) In Chad, the number of new users increased in 2019, however it did not reach the set target increase because the country had a higher baseline compared to Niger and Cameroon. On the other hand, in 2020, the number of new users remained close to the set target in Chad and Niger (Figures 24, 25 and 26). Due to reporting issues, data related to condoms was not included in the analysis so as not to influence the results.

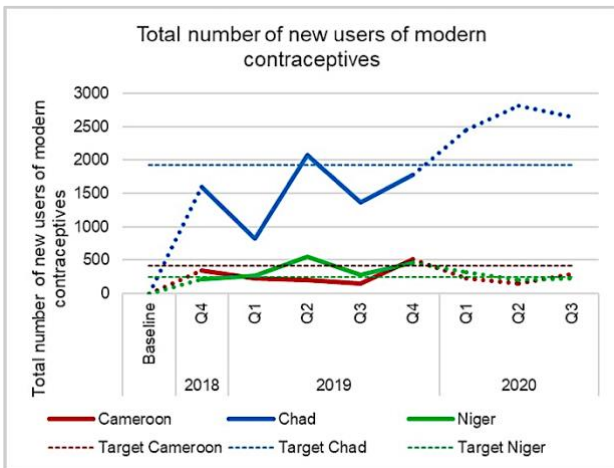
Nearly all modern methods were available at all times across all country sites, which is a significant improvement compared to the baseline, where on average, Cameroon facilities had 66% of key contraceptives and materials available; Niger 70%; and Chad 58%. Nevertheless, in Cameroon on average only 3 modern methods out of 8 were provided to clients, although on average 85% of the 8 modern methods were available. In Niger and Chad, a better method mix was used by clients, reaching nearly 6 in Niger by the end of 2019 (Figure 27).

Overall, there was a low uptake of Combined Oral Contraceptives (COC), the Intra-Uterine Device (IUD), and female condoms despite their availability. Emergency contraception was hardly used at all even though all staff were trained and sensitised about the use and advantages. There was no data available on the uptake/provision of permanent methods (tubal ligation and vasectomy). The district hospitals in Chad and Cameroon reported a lower number of contraceptive types used, probably due to the fact that in the immediate post-partum, especially in breastfeeding women, some methods are not indicated.

Figure 23. Total number of new users

Figure 24. Total number of new users

of modern contraceptives



of modern contraceptives, Cameroun

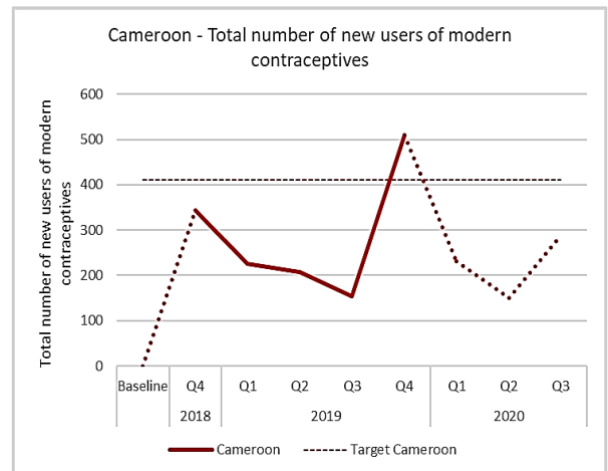


Figure 25. Total number of new users of modern contraceptives Chad

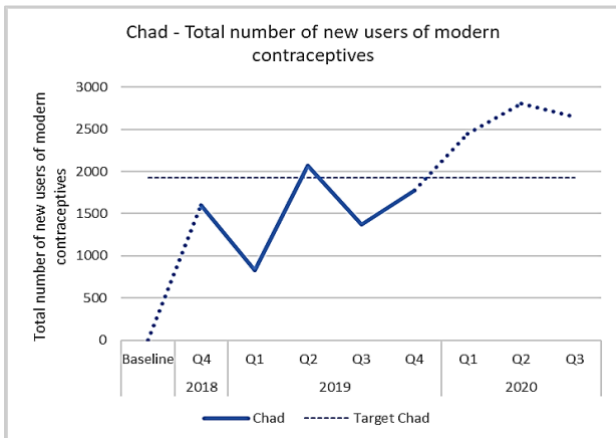


Figure 26. Total number of new users of modern contraceptives Niger

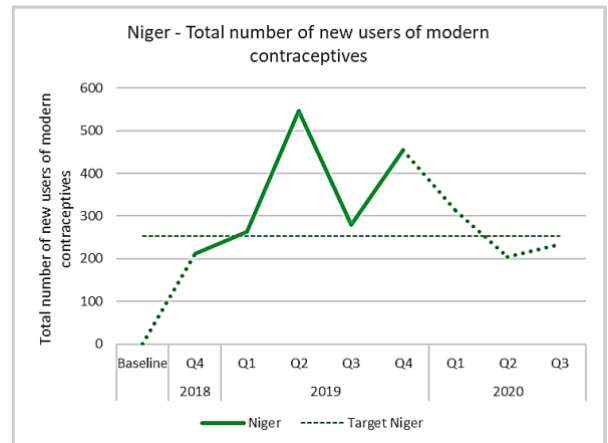
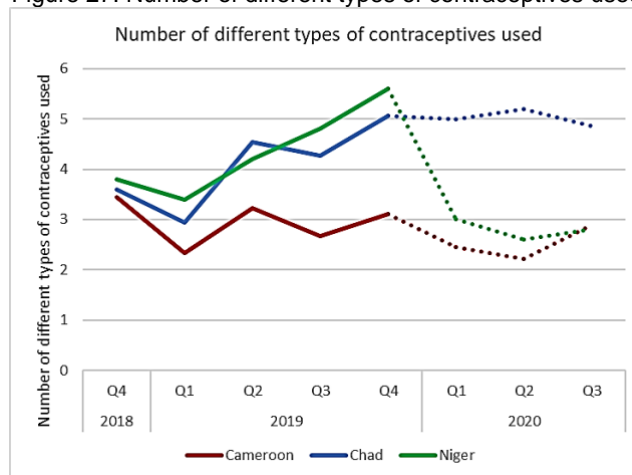


Figure 27: Number of different types of contraceptives used



Our analysis suggests that the low uptake in general - and of certain methods in particular - are linked to socio-cultural barriers, stigma and the fear of side effects. Availability of methods, training of health care

personnel and CHW, availability and use of guidelines, flipcharts and other IEC tools, have not been sufficient to reach the expected increase in FP use in Cameroun and Chad.

- **Unexpected outcomes**

Although the project did not analyse health outcomes in the host populations, the evaluation findings suggest that they indirectly benefitted from the project's outputs and outcomes and the increase in access to, and quality of, services.

3.3.4. Community-based interventions' contribution to the project objectives and continuum of care

The engagement of community workers and traditional birth attendants was crucial to the implementation, outcomes and linkage of the community to the health facilities. Most activities were carried out as planned as described in the Implementation section. Community workers were instrumental in awareness-raising, home visits for pregnant women and newborns, follow-up, and counselling on family planning and contraceptive options. They were also very important during COVID-19, helping to communicate with populations regarding the safety protocols in place to protect them during visits. The CHW training program was considered an important contributor to increased referrals of mother and neonates to the health structures. One key informant explained how valuable the training was for her as a healthcare provider at the clinical level and CHW at the community level, allowing everyone to provide improved specialized care for mothers and newborns: *The training transformed community workers into reproductive health workers" (CHW).*

Some limitations were identified that hampered the results of the program. Budget allocations allowed for training of CHW and purchase of tools, but stakeholders mentioned insufficient budget for implementing comprehensive community-based activities. The hiring of CHW was to be covered by the existing program, but their resources were found to be insufficient to cover the needs. For different organisations the purchase of individual baby scales surpassed financial responsibility. Insufficient community awareness materials (audio-visual, picture box, etc...) were also mentioned as a barrier to implementation of activities. The cost of printing counselling cards for each CHW was high and could not be met everywhere.

While different informers - including health staff, project personnel, and mothers - have vouched for the critical role played by CHWs, the project did not have an efficient monitoring and evaluation system in place to effectively measure community health outcomes and contributions as a result. The limited availability of data on CHW activities (referrals, home visits) does not appropriately reflect the value of their work. The increase of both home visits as well as referrals can be partly attributed by the CHW activities and training.

3.3.5. Capacity building activities' contribution to project objectives

UNHCR capacity building activities focused mostly on training activities for health staff, health facility managers and CHW. Such efforts were highly appreciated by a variety of stakeholders. The

overwhelming perception across respondents from all 3 countries is that the trainings increased participant knowledge of strategies for maternal and newborn care and led to notably improved practice: project staff, community workers and mothers testified to palpable improvements in the quality of Maternal and Newborn care and FP, availability of materials, medication and contraceptives. The involvement of Ministry of Health trainers and regional directors has also increased awareness and interest in training techniques beyond project sites.

High proportions of staff (60% in Cameroon, 67% in Chad and 78% in Niger) were trained in the different HBS and HMS modules within the timeframe. Both Ministry of Health staff as well as staff from the partner NGOs received training. Some sessions were open to non-project clinical staff, extending the reach of the project's impact.

Across all stakeholders, the LDHF methodologies with in-site availability of Master Trainers and training material were considered crucial for enhancing the quality of care for both refugee and host populations. In 9 months' time, 44 Master Trainers were trained during 7 rounds. The Master Trainers conducted nearly 1 000 LDHF sessions on maternal and neonatal health subjects in 1 year -- 431 in Cameroon in 9 health facilities, 502 in Chad in 15 health facilities and 56 in Niger in five (5) health facilities.

While pre-post test results demonstrated gains in knowledge and skills for all HBS, HMS and FP modules (as discussed in the implementation section), the project did not have indicators in place to measure long-term outcomes. Despite this, the training was perceived as a high-quality effective project that enhanced health staff performance, in particular the increase in quality in newborn and maternal health care provision. LDHF on-site modules permitted competencies to be maintained in low caseload facilities. While the metric targets were achieved, the evaluation did not find evidence of how UNHCR measured training effectiveness. There was no evidence of self-assessments, informal feedback from peers or job performance key performance indicators.

In Cameroon, post-test scores varied between 75% and 91%, with differences between pre-and post-test ranging from 6% to 34%. In Chad, the lowest post-test result was 65% and the highest 94%. Differences between the pre- and post-test results went as high as 41%. The training program showed high efficacy in Niger as well, with post-test results up to 93%.

In Chad, during the first round of Master Trainers, the trainer found that most of the participants did not have the profile to become a Master Trainer (difficult elocution, lack of knowledge of basic obstetrical care, lack of motivation, etc.), but the results of the tests showed good improvements in knowledge and skills.

In Chad, the delay in making funds available to the partner for implementation and the delay in the delivery of training material, as well as the low involvement of hospital maternity ward managers decreased the effectiveness of the trainings. The action plan and the provider's guide on the management of pre-eclampsia and eclampsia, the use of the suction cup and the MVA kit were not shared by the consultant in charge of this component.

According to the users of the WhatsApp groups created in each country, exchange on cases and LDHF sessions contributed to increase of knowledge.

Key informants reported that the FP training improved the knowledge and skills of health workers and contributed to increased uptake of family planning methods including long lasting methods. Training of all health care staff working in the outpatient departments contributed to an increase in FP uptake in men, unmarried women and adolescents. Because the FP data is not disaggregated by age or by marital status, it is not possible to robustly assess progress in FP uptake for those groups. There was a perception that more men may have been open to women using family planning after sensitization sessions. The data on pre- and post-test results was not available for all settings and could not be analysed.

In **Cameroon**, 223 out of the 368 CHW (60% of target) received training in 2018 and 2019. Tests demonstrated an increase in results from an average of 20% pre-training to 87% post-training during the training in 2018 and from 47% to 73% in 2019, indicating both the relevance and effectiveness of the learning. The CHW trainings contributed to increased referral from the community to the health facility (e.g., in the North), shortly after the CHW Helping babies and mothers survive module, 22% pregnant women and 36% of newborns and lactating mothers were referred to the health facility. In the eastern region, 244 referrals were reported during 1 262 home visits by the CHWs.

In **Chad**, all project sites conducted trainings of 437 CHW (approx. 80% of target), contributing to improved pre-post testing outcomes ranging from 30 to 90%.

Across 2018 and 2019, in **Niger**, 135 CHW were trained, demonstrating relevance and effectiveness with improved pre-post testing results ranging from 28% to 93%.

Feedback from FGD/KII with CHW demonstrated an overall satisfaction with the trainings as well as a perception of reduced maternal mortality, increased uptake of PNC, reduced complication rates for newborns, potentially due to earlier referrals, and continuous care for all newborns thanks to the home visits.

Evidence from the KIIs and document review suggest that the training in caring for mothers and newborns at home and equipment to conduct the home visits, in combination with weekly supervisions by the supervisors, has increased the number of referrals to the health facilities, even though this could not be confirmed by data. A mother interviewed explains the role of the CHWs in the referral process: *“Every three days after delivery, someone comes to check on us. If they see a problem, they refer us to where we can get help.” (RC)*

3.3.6. Sustainability of project activities and results

KEQ 5: To what extent does the project demonstrate: (a) sustainability in terms of the continuation of key activities and results in each country; and (b) successful institutionalization in UNHCR's global public health efforts?

- **Major factors affecting the sustainability of activities and results achieved**

Data from 2020 and 2021 indicate that several project results and activities have been sustained. LDHF trainings in Chad and Cameroon continued to be conducted by Master Trainers trained in 2018-2019. The impact of training and learning will continue through practice at project sites and beyond. At the health centre level, community workers and refugees themselves are important for sustainability. Maintaining WhatsApp groups within countries has supported the sustainability of mentorship and coaching processes for health care staff. Infrastructural upgrades and improvements will also continue to impact the quality of care for both refugee and host communities. Materials such as Kangaroo wraps continue to be made by local tailors to supply the KMC units. Despite loss of funds/personnel, current clinical staff are engaged and determined to carry on as best they can with the remaining staff.

The involvement of ministry of health trainers and regional directors allowed for increased awareness and interest in using the training technique beyond projects sites, greatly contributing to sustainability. Data from the first 9 months of 2020 indicate a continuation of capacity development activities, with more than 2 000 staff attending a LDHF session in Cameroon and Chad.

An important element affecting maximum sustainability of project activities and results is the lack of sufficient project funds for retaining trained site-level staff who were hired, and for updating supplies and infrastructure in already under-resourced health facilities and systems. It is expected that supervision will diminish as a result of lack of staff and funding.

- **Support necessary to maintain activities and results**

For sustained project impact and activities, funding is needed for infrastructure, supplies and materials, and to retain additional trained staff hired at the project sites. Sustainability is also dependent on the continued support, mentoring and coaching from Master Trainers and UNHCR. Long-term sustainability will be ensured when project activities and outcomes become integrated into national planning processes and funding.

- **UNHCR's institutionalization of project learning into their overall public health work**

To a large extent UNHCR has successfully institutionalised learning from the project using various methods, platforms and target groups. (See Annex 8) Lessons and tools about essential maternal and newborn care practices and family planning services, and strategies for their integration into UNHCR regular services, informed dissemination products and strategies. UNHCR had a strategic approach from the start of the project. Many of the targeted outputs were achieved within a short period of time. Examples of achievements are: the creation of informative educational materials (print and web-based), dissemination of findings and knowledge on the internal and external websites, in scientific journals,

through seminars, webinars and meetings. Different tools used in the project have been disseminated to operations worldwide.

Project approaches were disseminated globally, targeting:

- UNHCR Public Health, Reproductive Health & Nutrition Staff
- UN agencies
- Health & Nutrition Partner Staff
- Humanitarian and Development Actors
- Inter-Agency Working Group on Reproductive Health in Crisis (IAWG) members
- National health authorities & partners
- Academics
- Donors

In addition to the tremendous effort put into dissemination, lesson learning has informed UNHCR operational guidelines and UNHCR monitoring tools to improve implementation, quality and M&E of health programs.

Extensive work has been done on increasing awareness and knowledge of the importance of essential maternal and newborn care practices and family planning services as well as innovative strategies to better integrate them into UNHCR regular services. However, **although many of these strategies have been disseminated, the extent to which they have been integrated into regular public health programming is not known.**

3.3.7. UNHCR's Partnership with BMGF

KEQ 6: To what extent is the PHS-PSP-BMGF partnership strategic, and being cultivated to generate value for both UNHCR and BMGF?

The BMGF aims to support people in low-income countries achieve healthy productive lives by promoting innovation and global cooperation, creating market incentives and stimulating the generation of evidence. The Foundation has been engaging in support to emergency refugee assistance since 2006, with a growing focus on innovative public health technologies and approaches. A small but significant number of UNHCR projects have been funded including: sanitation activities in the East and Horn of Africa, public health interventions in Bangladesh and the current maternal/newborn healthcare project, as initially piloted across Jordan, South Sudan and Ethiopia. The current project is based on the BMGF approach of low cost, high impact solutions to achieve positive outcomes for Persons of Concern to UNHCR and is thus of value to both parties. The project has further established a relatively more elaborate monitoring system than normal for UNHCR in order to demonstrate evidence of this. It does not however, align well with the BMGF's wider geographical priorities for Africa (Burkina Faso, Ethiopia, Kenya, Nigeria and South Africa).

More broadly, collaboration with UNHCR provides the BMGF with an opportunity to support refugee, and more generally, forcibly displaced populations. Both parties target vulnerable populations in low-income

countries. The BMGF places significant emphasis on fostering long-term systemic changes at country level. As UNHCR seeks to apply the Global Compact for Refugees (and the humanitarian/development nexus approach), the agency is increasingly looking to support refugee inclusion into national health systems and thus, the strengthening of those systems and Ministries of Health with a view to finding longer-term solutions for protracted refugee situations. The current project has provided the essential building blocks for meeting basic maternal/newborn healthcare system needs and on which to build more sustainable change.

Whilst UNHCR has engaged with the BMGF regularly on this project, it is not clear to what degree both institutions have engaged in cultivating a broader and deeper partnership based on mutual values and interests or indeed, what this might entail. To date, UNHCR's engagement with the BMGF has focused primarily on emergency approaches.

4. Conclusions

4.1. Design

The project design was overall found to be pertinent in including the use of a baseline assessment, including a mixed method and participatory approach including populations of concern, to identify needs in order to ensure relevance to contextual realities. Low-cost, high impact interventions throughout the continuum of care and the cascade approach to training were highly appropriate for the contexts. The overall design was comprehensive, well-developed and adaptable to changing needs. The project was well aligned with the BMGF objectives, level of innovation and implications of resources with a focus on expansion of LCHI interventions. The relevance of the project was further accentuated by good levels of adaptability as a result of security and Covid-19 constraints. There was some concern that overall, the project did not sufficiently focus on access to, and quality of, C-sections.

4.2. Implementation

Strong partnerships, including coordination and collaboration, with ministries of health, partner NGOs, and other humanitarian and development stakeholders at regional or district levels in planning and the implementation stage contributed to the effectiveness and efficiency of implementing project activities. On capacity development, the high 80% success rates of the HMS, HBS, and LDHF training model and the training of CHWs were catalysts for the effective implementation of service delivery and demand generation. The recruitment of an international consultant was an efficient addition to upgrade the level of care.

Service delivery was upgraded through improving the facility structures, including renovation, the addition of health workers, ensuring consistent supplies, strengthened supervision and monitoring and evaluation of the project. Service delivery focused on implementing the comprehensive maternal and neonatal packages including the KMC which seemed innovative²⁰ for each of the three respective countries. Finally, the hiring of an overall project manager was key to supporting UNHCR HQ and country-level project staff from a technical and operational perspective.

One major challenge to implementation was the emergence of COVID-19, which required some adjustments to program activities, to clinic infrastructure and care provision set-up, and delays in supervision and monitoring visits to project sites. In addition, budget and security were reported as a constraint to implementing family planning and some outreach activities. Most importantly, **COVID-19 made travel to sites impossible for activities related to project evaluation.**

4.3. Results/Impact/Outcomes

Neonatal mortality rates dropped below the set target of a 25% decrease in all countries. The project has substantially increased essential LCHI care practices at birth and improved neonatal resuscitation.

²⁰ Definition Innovation: new for its context.

The availability of medicines and commodities to treat complications as well as the improvements in care for small neonates have contributed to the results in all three countries. The project has enabled all facilities to provide Kangaroo Mother Care to the majority of very low birth weight babies, increasing their chance of survival. Reinforced knowledge, skills and attitudes through on-site competency-based education has contributed to the quality of care. Training of all CHW in home-based care for newborns has not been achieved. As outlined above, the findings on the CHWs work and their impact on health outcomes have been constrained by the lack of evidence available due to limited data collection at the community level. Given the fact that the start-up phase of the project was long and activities only really started in October 2018, that capacity development activities take a long time to realise tangible outcomes, and that maternal deaths are a rare event – **assessment of the impact of project activities on maternal mortality rates require analysis of data from longer-term implementation**. The impact on stillbirths has not been tangible, but births in all countries have been too low to demonstrate statistically significant change. Nevertheless, essential low-cost practices at birth have been implemented successfully in all settings. All facilities are capacitated to provide at least 6 BEmONC signal functions out of 7. However, the small caseload and delays in training, as well as the unavailability of vacuum extraction, contributes to the low number of signal functions reported to be done. Nevertheless, the direct obstetric complications' case fatality rates remained within acceptable ranges for humanitarian settings in all the countries. Care has been compromised somehow in some facilities and during certain periods by stock ruptures in some essential medicines and medical material.

There is evidence that capacity development outputs have contributed to improvements in maternal and neonatal care, especially at primary health care level. Despite capacity building activities reaching 100% of the staff in family planning methods and counselling, efforts to increase contraceptive method-mix and the use of CHW for sensitization activities and **contraceptive use remained generally lower than targeted in Chad. However, the 2020 data is promising**. In Niger, the target for contraceptive use was met, a success attributed to existing efforts (“École des maris”) focused on acceptance at the community level, coupled with the project focus on availability. Cameroon managed to reach the target set of a 20% increase in new users of modern contraceptive methods by the end of 2019, but the number of new users decreased again in 2020.

Project healthcare staff, community health workers and mothers testified to palpable improvements in the quality of Maternal and Newborn care and FP, the availability of materials, medication and contraceptives. Training provided them with knowledge of strategies for maternal and newborn care that were not costly yet proved to be efficient. Several wondered why they had not received such information, such as KMC or resuscitation of newborns, as part of their professional training. They reported improved health practices and better equipped health centres resulting in a reduction in the number of referrals needed to district hospitals and reference health centres, and an increase in deliveries in health facilities. Health ministry staff and PHO noted that the data collected on maternal and neonatal mortality may not be demonstrable of a statistically significant decrease given that adequate calculations of rates were not possible due to the small numbers of deaths. All reported strong implementation and use

of essential practices, including KMC. Interviewees clearly specified that trainings were open to non-project clinical staff, thereby extending the breadth of project impact.

4.4. Budget/Economy

Generally, output targets were met in line with the allocated budget. No major budget gaps were identified. The overall actual expenditures are aligned with the overall original budget. Funds were disbursed as allotted. Flexibility in some budget lines were key, allowing for modifications by site as needed. The general feedback is that the budgets were insufficient, but the overall outputs and outcomes were relatively high compared to funds allotted. The funding was considered important by all stakeholders for all aspects: capacity development and the ability to increase primary health care level capacity to treat maternal and neonatal complications.

4.5. Sustainability

While prospects for sustainability are uncertain and depend largely on available finances, some outputs and outcomes at individual level demonstrate positive prospects and are supported by preliminary post-project qualitative and quantitative data obtained for 2020 and 2021. Improvements to infrastructure, materials, equipment, training tools and some drugs remain, as does the knowledge gained by health personnel and community workers who continue to draw upon their knowledge and experience to improve their practice. Some activities have continued into 2021 and have the potential to extend beyond this. For example, LDHF sessions continued in 2020 on a regular basis in Chad and Cameroun. Project staff have also continued the use of the WhatsApp communication mechanism that was successful for maintaining communication within country and served as an important mode of sustained mentorship and coaching of health care staff. Furthermore, in 2021, training is continuing and being disseminated in other countries. For example, a healthcare provider from Cameroon reported conducting training from this project in another country outside of project participants. Additionally, materials produced as a result of this project's activities are being disseminated at the global level and are available on the Web.

Despite some long-term gains, continuous funding will be the primary key to sustaining positive maternal and neonatal health outcomes. Cessation of the funding stream poses significant risk to the gains in maternal and neonatal health outcomes.

5. Good practices and lessons learned

The collaborative processes of assessment of baseline needs, design, implementation, monitoring and evaluation resulted in the identification of several good practices and lessons learned.

The implementation of LCHI strategies was based on an **extensive understanding of the contextual needs of the health systems** of each country and site through a baseline assessment. The project provided comprehensive activities that addressed the 6 building blocks of the health systems framework: service delivery, health workforce, health information systems, access to essential medicines, financing, and leadership/governance. The integration of elements from all 6 building blocks has been identified as important for enabling quality care, and in this context, was successful in promoting an environment for improved provision of MNC and FP. However, this approach does not address the strong influence of certain **socio-cultural factors that influence maternal and reproductive health**. Nevertheless, the project's inclusion of CHWs was a valid and important initial step towards helping address the social context.

The training of **Master Trainers from site-based facilities** was effective, ensuring continuous, as needed and case specific mentoring for staff at the health centres. The availability of training equipment and materials at sites facilitated further training of site personnel (cascade training model), hands-on practice, and retention of skills.

A continuum of care was ensured through the development of CHWs' capacity to conduct prenatal and postnatal home visits for pregnant women, mothers and newborns. Sensitisation activities, basic clinical assessments and early referrals were important factors leading to increased utilisation of MNH services as well as improving maternal and neonatal health outcomes.

Kangaroo mother care was a LCHI method highly emphasized in this project, resulting in high utilization. The project eliminated the primary barriers to KMC utilisation by addressing training needs, using hands-on training, and availability of guidelines translated into French.

Although the availability of BEmONC at all sites proved efficient, **better monitoring of the access to and the quality of C-sections, blood transfusion, and management of sick newborns**, might have helped to identify these gaps during project implementation.

M&E indicators needed to be commensurate with the project timeline. Expecting observed statistically significant changes in maternal and neonatal mortality rates was not reasonable within the timeframe, particularly considering the lack of an appropriate denominator. The project was successful at collecting facility-level data but lacked data from the beneficiary community level, which would have improved assessment of the impact of project activities.

The project manager (PM) was important to ensure support to the PHOs for the development, implementation, monitoring and evaluation of the project. A PM facilitating ongoing communication between country project staff (e.g., PHOs) would have been beneficial for the sharing of challenges and

successes. The fact that the PM was based at HQ was considered to somewhat hamper accessibility to the much-valued impact of the support.

Reproductive rights and respectful maternity care are important aspects of MNH & FP projects to be integrated and emphasized better in trainings, sensitization activities and supervision.

6. Recommendations

The following recommendations build the project's investment in the improved provision of maternal and newborn care among refugees in Cameroon, Chad and Niger. The following strategic actionable recommendations are drawn from multiple project data sources to inform future project design and implementation.

1. UNHCR should consider expanding the project for continued improvements in maternal and newborn care (MNC) and in FP for refugee populations in low-resource settings within the WCA region if not more broadly.

This recommendation clearly has cost implications at multiple levels:

At country level: UNHCR Senior Management, Public Health and Programme Teams

- a. Support sustainability and expansion of project activities with regards to training, provision of materials, supplies and infrastructure restoration, and awareness raising of MNC and family planning.
- b. Invest in the engagement and training of additional CHWs and healthcare staff at sites and at surrounding referral health centres. This includes identifying and implementing mechanisms for potentially better compensating CHWs' efforts.
- c. Increase access to, and the quality of, comprehensive emergency obstetric and neonatal care.
- d. Advocate for LDHF training content integration in national pre- and in-service training curricula through increased MoH involvement.

At regional bureau level: Senior Public Health Officer

- e. Foster communication, information and experience sharing between project country teams to reinforce efforts to improve overall cross-country public health performance following the departure of the project manager.

At global level: Senior SRH Officer /PHS

- f. Incorporate lessons learned from this project into UNHCR's strategic approach and upcoming new global public health strategy.
- g. Promote the inclusion of LDHF training in UNHCR supported MNC programmes and continue sharing lessons learned from the project as widely as possible with other country operations and agencies.

2. Consider MNH project integration into wider UNHCR public health programming and greater support to national health systems.

At global level: Senior SRH Officer /PHS

- a. Oversee the integration of MHN strategies into overall PH programming through for instance, propagating the use of low-cost high-impact interventions and other successful strategies for improving MNH in low resource settings.

- b. Foster support to local/provincial health systems in areas of operation in line with the Global Compact for Refugees.

3. UNHCR should consider strengthening the support it provides to partners in monitoring and evaluation (M&E).

Further assistance to partner NGOs aligns well with the roll-out of UNHCR's Results Based Management processes and the development of country-level M&E plans to improve the effective implementation of project activities through on-going lesson-learning, and periodic assessment of project impact:

At country level: UNHCR Public Health Teams (and Inter-Agency Focal Points)

- a. As part of the phased roll-out of multi-year strategic planning, increasingly ensure that MNH projects are integrated in, and based on, an overall theory of change to strengthen design and programme impact through credible, useful, cost-effective and evidenced-based strategies that are adapted to context and discussed with partners taking each one's role and contribution into account.
- b. Provide assistance to NGO partners to enhance the quality of health data collected based on the existing HIS and taking into consideration national data collection systems.
- c. Periodic assessment of quality of care using the Balanced Score Card. Data should also be collected from the beneficiaries (e.g., client exit interviews, focus group discussion, surveys) to gauge satisfaction with services and quality of care.
- d. Strengthen engagement with ministries of health with regard to the sharing of local and national surveillance data in order to improve the potential for the broader assessment of project impact beyond refugee sites. Facilitating easier access to national data will reduce data collection burden on local partner staff if the monitoring is better integrated and complements health ministries' surveillance efforts.

4. Future interventions among refugee populations in similar settings should factor in the importance of addressing persisting socio-cultural factors that affect behaviours in MNC and FP.

At country level: UNHCR Public Health Teams

- a. Further strengthen the focus on increasing acceptability of and demand for FP, in addition to the provision of contraceptives. This could be done through sharing and implementation of proven strategies in such countries as Niger where they implemented engagement of men and community/religious leaders ('École des maris' UNFPA program). Other strategies could include engaging community-based organizations that have proven successful in marketing approaches for SRH in similar context, as well as increasing women's empowerment through education and economic independence. Multi-sector collaboration would help ensure multiple aspects are addressed.

- b. Increase knowledge about and access to FP among adolescents, as conducted in Cameroon in this project. A life-course approach to SRH and early intervention have been shown to be key to improving FP globally.
- c. Better address the persisting verbal and physical abuse of mothers during pregnancy and delivery. Training modules included some elements of respect of women's rights as a step towards addressing this problem. Further educating providers and increasing women's knowledge of their rights is more likely to support institutionalising respect for maternal and reproductive rights. However, given the scale of this phenomenon, more work will be required to better understand the reasons behind harmful practices and identify potential ways to address them.

At regional level: Senior Public Health Officer in cooperation with relevant sections

- d. Create deeper linkages to address community norms together.

At global level: Senior SRH Officer/ PHS

- e. Consider promoting a wider evidence-based approach to family planning as integral part of overall public health programming to enhance access to modern methods of contraception.
- f. Foster the consistent inclusion of respectful maternity care trainings and standards into MNC programmes.

1. UNHCR should undertake a more strategic approach to its partnership with the BMGF (and other potential global health funders), one that is both transactional (based on funding), and non-transactional (based on a relationship of shared values and interests).

Specifically with the BMGF, there exists a strong convergence of values and interests that should be further developed drawing on, and moving beyond this project to look at wider issues of low-cost public health technologies and innovations, longer-term developmental objectives and collaboration as well as the scope to scale innovations/pilot projects in a wider range of countries that fall within the BMGF's wider geographical priorities.

At global level: PSP (with PHS)

PSP should consider developing stronger theories of change that generate the impact/value that a multi-year (transactional and non-transactional) partnership with a donor like the BMGF might generate according to the vision that UNHCR wishes to achieve and where there is commonality between the two institutions. Whilst this will require more creative thinking and brainstorming internally, partnership cultivation will no doubt need to incorporate a deepening of the relationship through stronger and wider articulation of mutual goals (healthy productive lives for vulnerable forcibly displaced populations in low-resource settings) and transformative objectives and processes that extend beyond emergency/short-term approaches and potentially, beyond current focal points/departments within both UNHCR and the BMGF.

7. Annexes

Annex 1: Terms of Reference

Evaluation of the project “Saving Maternal and Newborn lives in Refugee Situations” in Cameroon, Chad and Niger

Key Information at glance about the evaluation	
Title of the evaluation:	Evaluation of the project “Saving Maternal and Newborn lives in Refugee Situations” in Cameroon, Chad and Niger
Timeframe covered:	January 2018- September 2020
Type of exercise:	Project Evaluation (Decentralised Evaluation)
Evaluation commissioned by:	UNHCR Public Health Section
Evaluation manager’s contact:	schulteh@unhcr.org
Date	September 2020

1. Introduction

In January 2016 UNHCR started to implement a two-year project ‘Saving Newborn Lives in Refugee Settings’, aiming to improve neonatal care services with a focus on low cost, high impact newborn interventions in refugee camps in South Sudan, Kenya and Jordan. The project received support from the Bill & Melinda Gates Foundation. An evaluation was carried out in 2018, covering the period 1 January 2016 to 31 October 2017. Prior to this evaluation, positive effects had already been reported from the health providers, partners and MoH authorities as well as from UNHCR teams in the field who indicated that the project significantly contributed towards improving the quality and availability of health care services to mothers and newborns in the refugee settlements. UNHCR proceeded at an early stage with a request for the expansion of the project to three further countries hosting refugees and adding maternal health and family planning to the newborn approach. The project expansion was approved and received additional support from the Bill & Melinda Gates Foundation.

Building on the original ‘Saving Newborn Lives in Refugee Settings’ project, the **expansion of the project in 2018-2019** to Cameroon, Chad and Niger aimed to benefit from the consolidation of learnings and practice and an extension of action to address **targeted maternal, newborn and contraception/family planning care interventions known to save maternal and newborn lives**. The implementation of the expanded project ends 31 December 2019.

With the **end of project evaluation** UNHCR aims to assess achievements, enhance learning and to help identify contextual and organizational factors that may have had a particular enabling role in the project development and those that may have slowed progress. Further, the evaluation is meant to investigate the sustainability of the achievements in the current configuration of actors and funding and identify the essential support necessary to maintain achievement, potentially expand coverage and/or to complement any element

identified as missing or insufficient. Finally, the evaluation will include some costing analysis of the key components of the project per country.

2. Subject of the evaluation and its context

UNHCR aims to ensure that all refugees can exercise their rights to access essential public health services at the community, primary and secondary health care level.

The different settings of UNHCR's operations pose challenges due to the wide variety of health care systems, financing of health care and disease patterns and burdens, between regions, countries and even sub-regions within a country. Security and access to refugee populations can present an important additional challenge in terms of staff deployment, supervision and support visits, supply of essential medicines and medical equipment and the referral of patients. In some contexts, the national health care system is unable to address the national populations needs, and further struggles with the additional burden of refugees.

Women, girls and children are disproportionately affected in conflict and emergency situations. Globally, one in seven women will face a complication during pregnancy or childbirth. Every year, an estimated **295 000 women die during and following pregnancy**²¹; 94 percent of all maternal deaths occur in low and lower middle-income countries. Humanitarian settings present a particular concern: the lifetime risk of dying in pregnancy or childbirth for women in fragile settings (countries experiencing crisis or conflict) is estimated at 1 in 54 compared 1 in 5 400 in high income countries. Maternal deaths are defined as death occurring during pregnancy and childbirth and up to 42 days following the end of pregnancy. Direct causes of maternal mortality are those where the death is directly related to the pregnancy, related complications or interventions; the majority of maternal deaths are due to direct causes, most of which can be addressed with relatively simple means or prevented entirely. A recent analysis conducted by UNHCR of 72 audits of maternal deaths that occurred in 2018 in 29 refugee camps in seven Eastern African countries found a significant contribution of the third delay to maternal deaths and which highlights capacity gaps in provision of emergency obstetric care amongst NGO providers and national services. The analysis concludes that while evidence-based guidance on provision of quality Emergency Obstetric and Neonatal Care (EmONC) is available, implementation is often far behind.

2.9 million newborns die in the first four weeks of life, and 2.6 million more are stillborn, dying in-utero during the last three months of pregnancy. Neonatal deaths, defined as any death that occurs in the first 28 days of life, currently account for nearly 50 per cent of all deaths of children under five years of age in low- and middle- income countries. Approximately three-quarters of these deaths are early neonatal deaths that occur during the first week of life, including 36 per cent that occur within the first 24 hours after birth. More than half of all neonatal deaths occur in countries with a newborn mortality rate of 30 or more deaths per 1,000 live births. Many of these countries have experienced recent conflict or humanitarian emergencies and are hosting refugees. The three major causes of neonatal mortality are complications of preterm birth and low birth weight, infections, and complications that arise during the birth process (previously known as birth asphyxia). These causes account for more than 85 per cent of newborn mortality. Causes of newborn deaths in refugee settings are not different from causes of newborn death globally. However, underlying risk factors and conditions that contribute to newborn deaths can be exacerbated in refugee situations with inadequate shelter, poor sanitation and hygiene, poor maternal diets, limited access to skilled attendance at delivery, limited capacity for care in the first 24-48 hours after delivery, and low prevalence of early initiation and exclusive breastfeeding.

Access to contraception and family planning services is a human right and is an essential service in refugee operations. Scaling up access to quality contraceptive and family planning services can reduce maternal and

²¹ WHO maternal mortality – Key Facts Sep 2019. <https://www.who.int/news-room/fact-sheets/detail/maternal-mortality>

neonatal morbidity and mortality, prevent unwanted pregnancies, reduce rates of abortion and adolescent pregnancy and avert related risks (including unsafe abortion). Family planning also provides numerous societal benefits including supporting a sustainable environment, poverty reduction, better nutrition, improving girls' education and empowerment, and reducing HIV transmission, among others. Women in humanitarian crisis situations, including refugee settings are particularly vulnerable and their rights to access reproductive health services, including family planning, must be ensured. It is estimated that 225 million women of reproductive age in the developing world have an 'unmet need' for contraception – they would like to delay or stop childbearing but are not using any form of contraception. Past reviews of family planning services²² have found a number of barriers or gaps in family planning services in refugee operations. These include among others: inadequate and insufficient provision of modern contraceptives methods and low awareness about these methods; low uptake of contraception related to accessibility issues (distance and costs), lack of awareness, opposition to use, fertility-related reasons, and religious reasons; poor service quality, including disrespectful attitude by health providers, long waits, lack of privacy and confidentiality and poor hygiene in facilities. Provider-level barriers include poor training; lack of knowledge; biases; and hesitancy of health staff to discuss or offer contraception due to perceived sociocultural resistance²³

Understanding the reasons why new-borns die, understanding the factors affecting the coverage and quality of antenatal, intrapartum and postnatal care as well as those affecting access to and acceptance of contraceptive/family planning services are crucial for improving maternal and newborn health programming in refugee settings.

The project developed in Cameroon, Chad and Niger **emphasizes the expansion of key low-cost, high-impact interventions to address maternal together with newborn health**, including use of the partograph, active management of third stage labor, proper cord care, thermal care, initiation of breathing and resuscitation, early initiation of exclusive breastfeeding, kangaroo mother care and eye care as well **improving access to and acceptability of contraception/family planning** in refugee settings and other components of EmONC in three selected countries.

The central activities carried through the project in 2018 and 2019 present as follows:

1. **Baseline assessment, detailed design of project, monitoring, programme evaluation, learning and dissemination** – Understanding context-specific needs is the first step in improving health programming. Because refugee operations differ considerably in the robustness and reach of health services, programmes must be tailored to the specific opportunities and constraints of the setting to be effective. A baseline assessment was carried out by UNHCR in the three countries to understand context-specific needs and factors which fed into the country specific project design. The information and recommendations provided by the baseline assessment were used to plan the most appropriate interventions to improve services and reach the outcomes. Building on the past project in South Sudan, Kenya and Jordan, a systematic documentation of experience and monitoring tools was started from the beginning of the project to enable regular follow up of the progress and learning from the project implementation in the target countries.
2. **Capacity building of human resources** – The project invested into capacity building to promote access to quality emergency obstetric care, essential newborn interventions (including KMC), antenatal and postnatal care; promotion of early initiation of exclusive breastfeeding for all newborns and contraception/family planning services. Training improved professional competencies of skilled health providers such as doctors,

²² <http://www.conflictandhealth.com/content/9/S1/S3%0ARESEARCH>

²³ <http://www.unhcr.org/4ee6142a9.pdf>

nurses and midwives, targeted the provision of the seven basic EmONC signal functions, and respectful maternity care. Training followed a cascade approach using training of trainers from each project site and used the low-dose, high frequency methodology with the core subjects from the Helping Mothers Survive and Helping Babies Survive packages. Specific training was developed to increase knowledge and understanding of lay-persons (home visitors, community health workers, traditional birth attendants, ancillary staff) and to strengthen their role in conducting pregnancy and postnatal home visits, community mobilization and improving access to services.

3. **Strengthen health facility readiness and quality.** The project ensured the overall capacity of the health facilities to provide essential maternal and newborn services and family planning services by putting into place, renovating and maintaining the essential component of functional health services: essential amenities, essential equipment, standard precautions, laboratory tests, and medicines and commodities. The readiness and quality were ensured through: a) availability of skilled health providers through training, on-site supervision and mentoring; b) ensuring guidelines in place for maternal, newborn care and contraception services; c) providing adequate commodities, supplies (including Kangaroo wraps, caps and towels as well as basic materials for CHWs) and equipment for health clinics to implement clinical protocols and provide a range of modern contraceptive methods; d) engaging communities and promoting pre-conception, contraception, delivery and post-natal care; e) promote quality assurance by utilizing tested balanced score cards, and regular supervisory visits; f) reinforcing technical support system through regular structured support visits and meetings, measuring progress and identifying gaps; g) strengthening the referral systems
4. **Comprehensive family planning** - Contraception prevalence rate is very low in the three countries. To increase the use of family planning methods the project addressed the following: 1) overcoming stigma and promoting family planning through strengthening sensitization at community level; 2) ensuring availability of a full range of modern contraceptive methods; 3) ensuring clinical guidelines and appropriate counselling materials in all health facilities; 4) reinforcing training on contraceptive methods and counselling to health providers (doctors, nurses and midwives) as well as training of CHWs and TBAs on basic family planning concepts; 5) reaching vulnerable populations, including adolescents through the provision of context specific services.
5. **Community-based programmes** - In addition to standard facility-based maternity and neonatal care, community-based programs were considered. Community-based programs that are well integrated into primary health services can help ensure a continuum of care and provide linkages to facility-based services. Community-based interventional care packages were found to reduce maternal morbidity by 25%, stillbirths by 16%, perinatal mortality by 20%, and neonatal mortality by 24%. They play a key role in behaviour change in communities, as evidenced by a 40% increase in referrals to health facilities for maternal complications and a 94% improvement in the rates of early breastfeeding. Community-based approaches that were considered in the different projects include: 1) building or expanding community-based support groups on basic RH issues, such as women's groups, Mother's Groups, or breastfeeding support groups, youth groups, which can create a network of support for RH and related concerns; 2) training CHWs and traditional birth attendants on evidenced based activities regarding maternal and newborn care (breastfeeding, danger signs, cord care), family planning, promoting ANC and PNC visits to health facilities, and strengthening community-based referrals for mother and newborns; 3) Implementing a program of pregnancy and postnatal home visits, which in addition to training, included implementing a fixed schedule and content of visits, supervision plan, register and communication with health facility, among other program supports 3) increasing IEC and sensitization programs on a community level to promote use of family planning.

6. **Expanding learnings to an organizational level** - Through the two phases of the project (2016-2018 and 2018-2020), common gaps in service delivery and management have been noted across countries and operations. In order to disseminate learnings and integrate innovative practices into other UNHCR operations, a Communication and Dissemination matrix was developed in 2019. Activities include the development of guidance materials targeted at the managerial level in order to build capacity in managing RH/MNH, such as: development of operational guidelines; webinars for management level UNHCR staff (Public Health Officers and managers of NGO partners) on improving newborn (n=2) and maternal (n=2) health and family planning (n=2) in refugee settings; and the development of short High Impact Practice primers to aid implementation of key interventions (e.g. KMC, neonatal resuscitation). Other activities include: a field support mission to additional operations (Bangladesh) to support RH/MNH service development based on lessons learned from BMGF project implementation; the addition of essential contraceptive, maternal and neonatal medications and equipment to UNHCR's Essential Medicines List (e.g. kangaroo wraps, feeding cups, tranexamic acid, DMPA-SC, etc) based on gaps identified through the projects. External communication activities included: dissemination of baseline assessment findings; participation in/presentation at IAWG Newborn Health in Humanitarian settings experts meeting, and ongoing participation in development of 5 year strategy roadmap; presentations of project lessons learned at IAWG global meeting 2020; participation in a Spotlight session at the Global Refugee Forum highlighting maternal and neonatal deaths and, in particular, the project in Chad; publication of 2 peer-reviewed qualitative articles from the first phase of project; and re-development of UNHCR's public health website in order to make support materials more easily available to country operations.
7. **Reproductive, maternal and neonatal health population-based survey** – A population-based household survey on key RH, maternal and newborn indicators was carried out in Chad and Cameroon in 2018/2019. In addition to the primary findings, UNHCR is coordinating with experts to further analyse the survey data - US Centre for Disease Control for re-confirmation of primary data analysis and University of Washington for secondary data analysis on any correlates of low birth weight.
8. This **evaluation is part of the project funded by a grant from the Bill and Melinda Gates Foundation Emergency Response Fund**. The partnership with the Gates Foundation for maternal and newborn health started first in 2016 and then received this additional support for the 3 francophone countries in 2018. It is an important relationship for the UNHCR Public Health Section as the Gates Foundation is one of the few development actors who have developed emergency response funds that look at innovative approaches. Further, The Gates Foundation is well known for its expertise and leverage in the area of public health and has an important portfolio of support to maternal and newborn health initiatives. The BMGF is known to be a demanding donor; the requirements in terms of monitoring and concrete results is seen as an added value and corresponds to UNHCR own ambition for better data, for systematic death reviews and for the documentation of successes and failures to improve future performance.

9. Purpose and objectives

The main purpose of this evaluation is to assess the relevance, effectiveness and sustainability of the “Saving maternal and newborn lives in refugee situations” project in the three targeted refugee operations and the replicability of the approach in other contexts where UNHCR operates. The evaluation should show results from the project and help to identify contextual and organizational factors that may have had a particular enabling role in project implementation and those that may have slowed progress. The evaluation is meant to assess the sustainability of the achievements in the current configuration of actors and funding and identify the essential support necessary to maintain achievements, potentially expand coverage and/or to complement any element identified as missing or insufficient. Finally, the evaluation should include some expenditure analysis of the key

components of the project per country. A secondary purpose of the evaluation is to inform the Public Health Section's strategy and guidance with regards to maternal and child health and reproductive health programming, such as important standards, monitoring tools, and practices that are needed to ensure quality services to persons of concern. As well, the evaluation should provide insight into how different operations sustained gains since the emergence of the COVID pandemic. Last, the evaluation should also shed light on indispensable elements to strengthening the partnership with not only the Gates Foundation but also other potential donors in the future.

The evaluation will be used both for learning and accountability; findings will be used to guide programme practices to improve maternal, newborn and contraception/family planning care in refugee operations; and to demonstrate what worked well, why, and lessons learned from implementation to the funders and organizational leadership.

Specifically, the evaluation seeks to address the following and provide specific, actionable and practical recommendations for strengthening programming, operational guidance and partnerships:

- Evaluate the extent to which project objectives and proposed outcomes were achieved by measuring performance against each performance outcome indicator under each result area. Identify key determinants that, positively or negatively, influenced the achievement (or not) of these results.
- Compare different project countries and project sites, identify enabling factors and factors that may have slowed progress. Evaluate project budgets and conduct an expenditure analysis.
- Evaluate the effectiveness and efficiency of the organisational set-up for the project, tools and systems used in the delivery and monitoring of the project and to what extent these contributed to delivery of the project outcomes.
- Assess the sustainability of the individual project components, and identify critical factors that may affect sustainability and recommend support necessary to maintain achievements, potentially expand coverage and/or to complement any element identified as missing or insufficient.
- Provide recommendations on future project design including how to ensure planning, management, monitoring and evaluation frameworks are more effective and taking account of above factors.
- Assess developments in projects gains (monitoring data, utilisations of services in 2020) since the emergence of the COVID pandemic and until mid-2020.
- Examine the partnership between UNHCR and the Gates Foundation with regards to expectations, communication, collaboration, etc. to identify areas that can/have to be strengthened to enhance the partnership going forward and indispensable elements to project management and support. An assessment of the potential future partnership options between UNHCR and BMGF was done by PSP in 2019 and should be considered

The draft findings will be presented to partners in the respective project countries for validation and the draft evaluation report will be shared for comment with all evaluation stakeholders.

A final report will be prepared and shared with all UNHCR public health staff globally and will be discussed at the coordination meetings in each project country to ensure ownership of the Management Response following the evaluation. The same final report will also be shared with health partners in respective countries by the public health officers and made available on the UNHCR public website.

3. Evaluation Approach

3.1. Scope

The evaluation scope – relating to population, timeframe and locations– is as follows:

Timeframe to be covered in the evaluation: April 2018 – 31 July 2020.

Population location and details:

Cameroon

- In the Extreme North of Cameroon, 57,000 Nigerian refugees live in Minawao refugee camp, with 30,000 others living in sites outside the camp. Minawao camp has 2 health centres, one of which provides delivery services. The health partner is International Medical Corps (IMC).
- In the East of Cameroon, UNHCR is supporting more than 185,000 refugees from the Central African Republic in 38 health centres and seven health districts. For this project five locations were chosen, including four refugee sites and one host village (Gbiti) where many refugees are living together with the host population on the border with the Central African Republic (RCA). In addition, three district hospitals that serve as the main secondary level of care were included: DH Batouri, DH Kette and DH Garoua-Boulai. The health partner in the East region is African Humanitarian Action (AHA).

Chad

- In the South of Chad, 98,645 refugees fleeing war in the Central African Republic are living in multiple districts along the border. This project includes six refugee camps and their five primary health centres, supported by three district hospitals. The health partners in the South are Association pour Développement Economique et Sociale (ADES) and CSSI.
- In the East of Chad over 332,048 Sudanese refugees fleeing war in the Darfur region have occupied 12 camps for more than a decade. This project focuses on five camps and their primary health centres, supported by two district hospitals that serve as the secondary referral hospitals. The health partner in the East is the International Rescue Committee (IRC)

Niger

- In the south of Niger, more than 100,000 Nigerian refugees have fled Boko Haram, and are living in settlements along the border, integrated with internally displaced persons and the host population. Around 13,000 also live in the camp of Sayam Forage, which is the main site included in this project.
- In the south-west of the country around 56,000 refugees from Mali live in three camps (Tabareybarey, Mangaize and Abala) as well as Intekane, a “Zone d’Accueil de Réfugiés” (ZAR), an area where refugees are able continue their semi-nomadic life. The project includes the health centres in each of the four sites. The health partner for both regions in Niger is the Association Pour le Bien-Être (APBE).

Key Evaluation Questions (KEQs) and Sub-questions (SUQs)

The evaluation will address the following headline questions. The analysis needed to answer them is likely to touch on other possible sub-questions that may be further refined during the evaluation inception phase.

Key Evaluation Question on relevance of the project design:

- **KEQ 1:** To what extent are the activities of the 2018-2019 project (baseline assessment, capacity building of human resources, strengthening of health facilities, community-based programmes, organizational learning activities, RH survey, etc.) relevant and appropriate for the overall goal of the project to improve maternal, neonatal and contraception/family planning care services in Cameroon, Chad and Niger?
 - **SUQ 1.1.** How could the project design and the choice of activities be strengthened to improve its relevance to reaching the goal of the project? How does this vary or not across the different country contexts?
 - **SUQ1.2.** To what extent does COVID-19 affect the gains of the project's activities? How did the partners cope? How, if at all, should this be considered in MNCH and RH programming going forward and particularly regarding additional strains on the health services?

Key Evaluation Question on effectiveness of project implementation:

- **KEQ 2:** To what extent was project implementation in each country delivered as intended in the following areas: capacity building of care providers, health facility strengthening, comprehensive maternal and newborn care packages, comprehensive family planning services, good practices and guidance to improve care? Did implementation vary between countries?
 - **SUQ 2.1.** To what extent did the organisational set-up of the project, the tools and systems used in the delivery of the project contribute to timely implementation?
 - **SUQ 2.2.** What were the major factors influencing the implementation of the project as intended? Did factors vary by context? If so, how?
 - **SUQ 2.3.** Which enabling and challenging factors, if any, should be taken into account in future program implementation, bearing in mind constrained budgets and both a) normal circumstances and b) COVID-19 context? What enabling conditions/standards are necessary and why?
- **KEQ 3:** What were the budgeted and expenditure levels of implementing key components of the project and the project across the three contexts?
 - **SUQ 3.1.** What were the main drivers of expenditures? Did this vary by context?

Key Evaluation Questions on contribution to results:

- **KEQ 4:** To what extent did the project reduce maternal and neonatal mortality and morbidity and what were the major factors that influenced changes in mortality and morbidity in targeted populations in Cameroon, Chad and Niger? To what extent did the project increase contraceptive uptake? A detailed table of key outcomes is available in Annex 1.
 - **SUQ 4.1.** To what extent did the community-based programme contribute to the project objectives? How, if at all? Did this vary between contexts? Why/why not?
 - **SUQ 4. 2.** What, if any, important changes were noted since the emergence of COVID?

Key Evaluation Question on sustainability:

- **KEQ 5:** To what extent does the project demonstrate sustainability in terms of the continuation of key activities of value and sustaining results in each country?
 - **SUQ 5.1.** What are major factors that affect the sustainability of activities and results achieved from the project in each country?
 - **SUQ 5.2.** What support will potentially remain necessary to maintain activities and achievement, and/or to complement any element identified as missing or insufficient in each context?

- **SUQ 5.3.** To what extent has UNHCR institutionalised these approaches to maternal and neonatal health and family planning into their public health work globally? What other actions could UNHCR take to better incorporate learning from this project into their public health programming globally?

• Key Evaluation Question on global partnerships:

- KEQ 6: How does the PHS envisage its partnership with the BMGF? What are indispensable elements for the PHS in order to be able to adequately program and manage its partnership with Gates and other donors? What factors enable/hinder its efforts that would need to be strengthened to better leverage these partnerships in the future?

3.2. Approach and methodology

The methodology – including details on the data collection and analytical approach(es) used to answer the evaluation questions – will be designed by the evaluation team during the inception phase and presented in an evaluation matrix. Due to COVID-19, field travel is not anticipated. All data collection will have to be done remotely.

The evaluation methodology is expected to:

- Refer to and make use of relevant internationally agreed evaluation criteria such as those proposed by OECD-DAC and adapted by ALNAP for use in humanitarian evaluations²⁴.
- Employ a mixed-method approach incorporating qualitative and quantitative data collection and analysis tools including the analysis of monitoring data – as available, by measuring the following outcomes listed and detailed in Annex 1:
 - Reduced maternal and neonatal morbidity and mortality
 - Improved maternal and neonatal care practices of health care workers, including uptake of specific practices such as kangaroo mother care
 - Improved counselling for and provision and uptake of contraceptives
 - Strengthened community-level activities such as improved capacity for pregnancy and postnatal home visits

The evaluation team is responsible to gather, analyse and triangulate data (e.g. across types, sources and analysis modality) to demonstrate impartiality of the analysis, minimise bias, and ensure the credibility of evaluation findings and conclusions. It will try to document good practices and lessons learned to improve maternal, neonatal and contraceptive/family planning care.

Qualitative data sources should include but are not limited to phone/virtual key informant interviews and focus group discussions with UNHCR staff at HQs and country levels, partner staff, Gates Foundation, government line ministry and operational partners, as relevant. Virtual workshops and other participatory approaches should be used to solicit information in an interactive way, such as outcomes mapping, outcomes harvesting, etc.

Quantitative data sources should include use of secondary data sources, which are listed below. Since there has been an abundance of survey data collected from refugee households, any further collection of household

²⁴ See for example: Cosgrave and Buchanan-Smith (2017) *Guide de l'Évaluation de l'Action Humanitaire* (London: ALNAP) and Beck, T. (2006) *Evaluating Humanitarian Action using the OECD-DAC Criteria* (London: ALNAP)

surveys is undesirable. Brief Knowledge, Attitude and Practice type assessments with health care providers would be possible.

Data and information sources including the following existing sources:

- Project background documents and training reports;
- UNHCR's Health information system (HIS): data can be used to provide monitoring data on service coverage and health outcomes;
- Facility registers and other routine data sources can be used to assess patient needs and provide indications of program quality;
- Trimester reports from all health facilities supported through the project;
- Facility checklists that were used by UNHCR/partners to monitor facility capacity for service provision;
- Standardized Expanded Nutrition Survey, which was used to monitor early initiation of breastfeeding and exclusive breastfeeding as well as the proportion of pregnant women reporting receiving iron and folic acid supplementation from ANC facilities.
- Birth, maternal and newborn death reports, stillbirth data and maternal death audits from HIS data and maternal mortality reports completed by NGO health partners.
- Reproductive, Maternal and Neonatal population level survey data
- Baseline assessment in 2018.

3.3. Evaluation Quality Assurance

The evaluation consultants are required to sign the UNHCR Code of Conduct, complete UNHCR's introductory protection training module, and respect UNHCR's confidentiality requirements.

In line with established standards for evaluation in the UN system, and the UN Ethical Guidelines for Evaluations, evaluation in UNHCR is founded on the inter-connected principles of independence, impartiality, credibility and utility, which in practice i.a. call for: protecting sources and data; systematically seeking informed consent; respecting dignity and diversity; minimising risk, harm and burden upon those who are the subject of, or participating in the evaluation, while at the same time not compromising the integrity of the exercise.

The evaluation is also expected to adhere with the 'Evaluation Quality Assurance' (EQA) guidance, which clarifies the quality requirements expected for UNHCR evaluation processes and products.

The Evaluation Manager will share and provide an orientation to the EQA at the start of the evaluation. Adherence to the EQA will be overseen by the Evaluation Manager with support from the UNHCR Evaluation Service as needed.

4. Organisation, management and conduct of the evaluation

The UNHCR Public Health Section will serve as the **Evaluation Manager**. They will be responsible for: **(i)** managing the day to day aspects of the evaluation process; **(ii)** acting as the main interlocutor with the evaluation team; **(iii)** providing the evaluators with required data and facilitating communication with relevant stakeholders; **(iv)** reviewing the interim deliverables and final reports to ensure quality – with the support of the Evaluation Service at HQ.

The **Evaluation Team** should comprise a senior team leader and a second experienced evaluator. The team is expected to produce written products of high standards, informed by evidence and triangulated data and analysis, copy-edited, and free from spelling and grammatical errors.

The language of work of this evaluation will be in English and French and the deliverables will be in English.

5.1 Expected deliverables and evaluation timeline

The evaluation should be completed from October 2020 to December 2020 and will be managed following the timeline tabled below.

The key evaluation deliverables are:

- Light inception report with evaluation matrix, data collection toolkit (including interview guides, workshop outlines) (max 10 pages excluding annexes)
- Preliminary findings validation workshop with UNHCR Public Health Section and Country Offices
- One synthesis evaluation report including recommendations (max 50 pages excluding annexes)
- Power Point Presentation for purpose of dissemination of the evaluation findings
- Executive summary in English and French²⁵
- All raw data (quantitative and qualitative) collected should be anonymised and provided to UNHCR Evaluation Service.

Activity	Deliverables and payment schedule	Indicative timeline	Minimum # of estimated days
Phase 1: Inception phase including: <ul style="list-style-type: none"> - Initial desk review and key informant interviews. - Circulation for comments and finalisation 	Final inception report max 10 pages excluding annexes– including methodology, refined evaluation questions (as needed) and evaluation matrix; virtual support requirements for data collection (Zoom account, etc). <u>PAYMENT 25%</u>	Late Oct. 2020	16
Phase 2: Data collection and analysis: <ul style="list-style-type: none"> - Virtual interviews/workshops with UNHCR staff and partners (HQs and countries); Gates Foundation. - Data analysis of each country - Data analysis across countries - Facilitate validation workshop of preliminary evaluation findings, conclusions and proposed recommendations 	<u>ALL SECONDARY AND PRIMARY DATA COLLECTED ACROSS 3 COUNTRIES AND HQ.</u> Facilitation of a validation workshop of preliminary findings, conclusions and recommendations with UNHCR HQ <u>PAYMENT 50%</u>	Nov- Dec. 2020	36
Phase 3: Report drafting and finalisation <ul style="list-style-type: none"> - Draft synthesis evaluation report - PowerPoint presentation of findings and recommendations - Finalise report 	1 synthesis evaluation report across all 3 countries and HQ-level with executive summary in English and French 1 PowerPoint presentation of findings and recommendations All raw data anonymised <u>Payment 25%</u>	Dec. 2020	20

²⁵ The evaluation ToR, final report with annexes, and formal management response will be made public and posted on the evaluation section of the [UNHCR website](#). All other evaluation products (e.g. Inception Report) will be kept internal.

5. Evaluation team qualifications, selection and contracting

The evaluation will be undertaken by a team of a team of independent consultants – an evaluation Team Leader and 1 Team Member – selected by means of a competitive selection process.

The evaluation consultants' **selection** process will be carried out by the UNHCR Public Health Section in cooperation with the Evaluation Service. In line with the UNHCR Evaluation Policy, prior to hiring the consultant(s)/Evaluation Team, any actual or potential conflict of interest will be assessed.

Contracting will be via individual consultancy contract. Only proposals submitted by a team of consultants will be reviewed, and each member of the team will be contracted separately.

Functional requirements for the individual consultants – who should both be able and willing to travel to the selected sites are as follows:

Evaluation Team Leader

- Advance university degree in public health or related health field.
- A public health or clinical background (nurse, medical doctor) with a strong experience in maternal/newborn health care and contraception/family planning.
- At least 13 years' experience in the area of maternal, newborn and child health and public health, preferably in programmes in low resource settings.
- Track record of experience in project evaluations, particularly multi-country evaluations.
- Strong expertise in both qualitative and quantitative data analysis and research methods.
- Proven experience in leading an evaluation team in challenging contexts.
- Experience in the formulation, monitoring and evaluation of MNCH projects
- Experience working with refugees and/or in humanitarian settings would be desirable.
- Familiar with costing RMNCH programmes and conducting cost-effectiveness analysis
- Excellent spoken, writing and reporting skills in French and English.
- Good communication skills

Desirable: understanding of the forward vision regarding the refugee context and assistance to refugees, namely the Global Compact on Refugees, and inclusion and integration of refugees into national policies, strategies and systems.

Evaluation Team Member

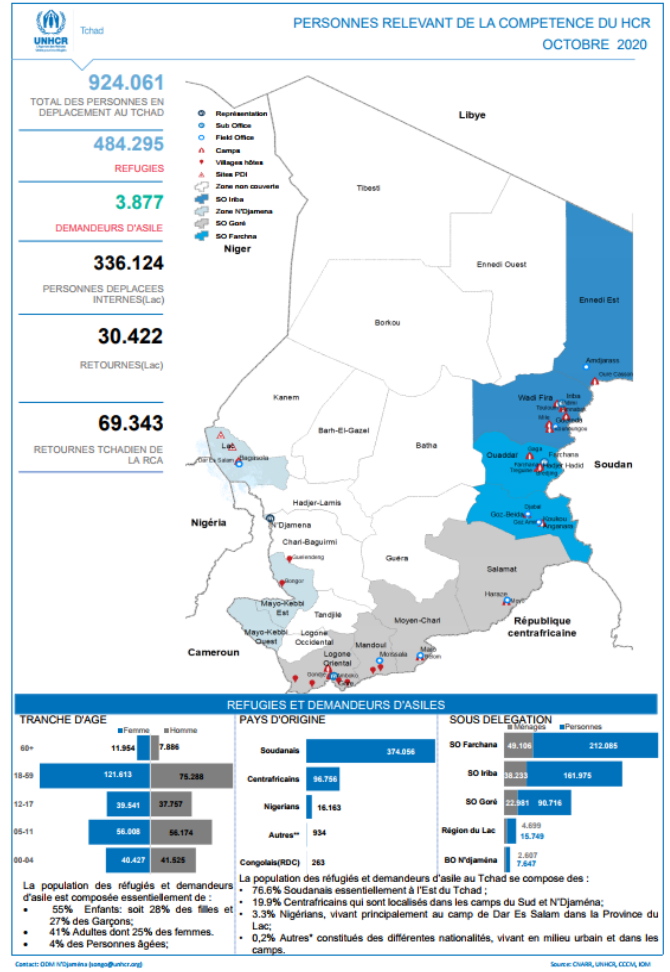
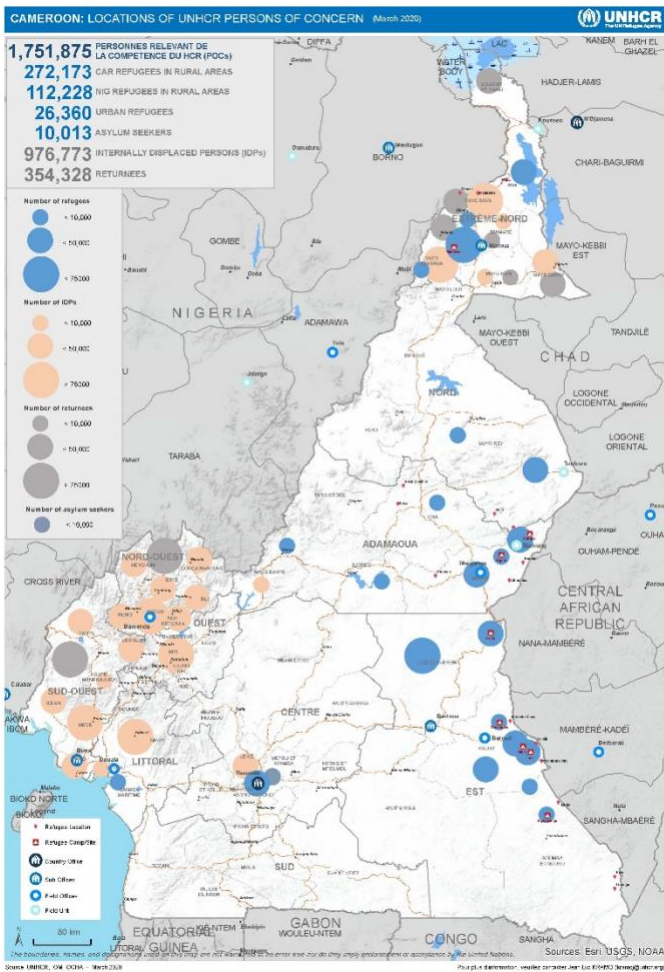
- Post graduate degree in public health or medicine
- At least 11 years of experience in maternal, neonatal and child health or sexual reproductive health (SRH)
- programmes in resource limited settings
- Strong programmatic and M&E experience in MNCH or SRH interventions in Africa
- Advanced experience in quantitative data analysis and research methods
- Strong report writing and presentation skills
- Track record of project management expertise
- Excellent spoken and written French and English
- Good communication skills

Annex 1: Outcome Matrix

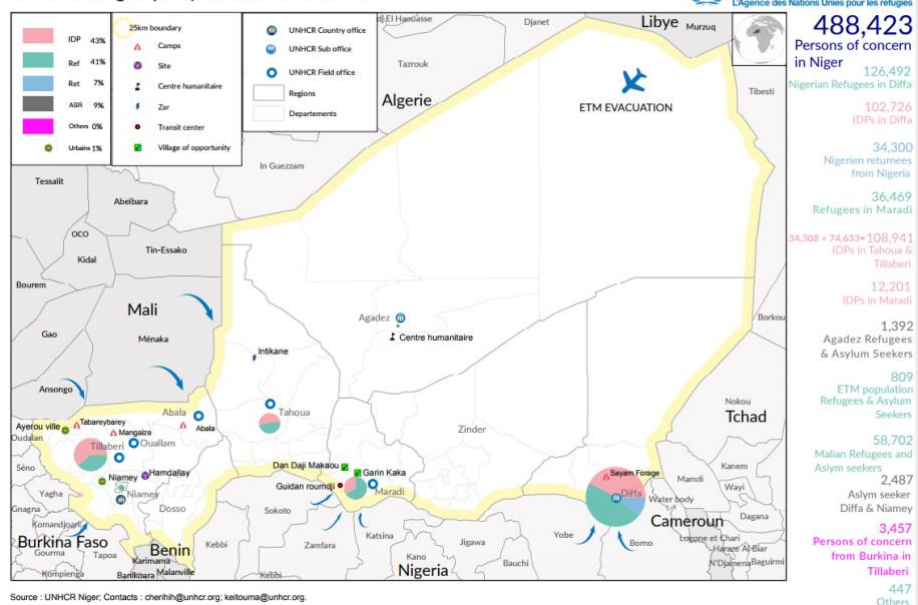
ID	Outcome/ Output	Indicator(s)	Data Sources (If Applicable)	
1		Quality, comprehensive essential newborn health care provided	NMR per camp/site (number of neonatal deaths per 1000 live births)	UNHCR Health Information System (HIS) and program reports (Niger)
	1.1	Capacity of health providers and community based health workers on essential new-born interventions strengthened	Number and % of health providers and CHWs trained in essential newborn care	Training report; programme reports.
			% of health facilities providing KMC	Facility checklists
			% of babies < 2000 g placed in KMC	Facility checklists
	1.2	Adequate new-born supplies, equipment and guidelines/protocols to health clinics have been provided	% of health facilities with functioning newborn bag and mask available	Facility checklist
			% of HFs with KMC wraps available	Facility checklists
2		Quality comprehensive maternal health services improved	Maternal mortality (crude numbers)	UNHCR Health Information System (HIS) and program reports (Niger)
		-	Stillbirth rate per camp/site (number of stillbirths per 1000 live and stillbirths)	UNHCR Health Information System (HIS) and program reports (Niger)
		-	Average number of 7 signal BEmONC functions performed in the past 3 months	Facility checklist
	2.1	Capacity building of human resources: training of the health providers on routine and emergency obstetric care	Number and % of qualified health providers trained on routine and emergency obstetrics	Training reports; programme reports
	2.2	Adequate maternal supplies, equipment and guidelines/protocols provided to health clinics have been provided	% of essential equipment for childbirth care available in each health facility	Facility checklist
			% of essential medications for childbirth care available in each health facility	Facility checklist

-	-	-		% of HFs have clinical protocols and guidelines available (*detailed reproductive health and HIV guidelines BSC-RH)	Balanced scorecard; facility checklist
3	-	-	Quality comprehensive family planning services improved	Contraceptive Prevalence Rate	Survey Facility checklist Number of new users of modern contraceptive methods
-	3.1	-	Capacity building of human resources: training of the health providers and community based health workers on contraceptive counselling, contraceptive modern methods and sensitization and promotion strategies strengthen	• Number and % of qualified health providers (doctors and midwives) trained on contraceptives methods and counselling	Training reports; programme reports
-	-	-		Proportion of postnatal clients who are offered counselling on family planning	Survey
-	3.2	-	Adequate contraceptive maternal supplies, equipment and guidelines/protocols provided to health clinics have been provided	• % of modern contraceptives methods provided by health facility to clients over the last 3 months	Facility Checklist
-	-	-		% of health facilities fully equipped with modern contraceptive methods	Facility checklist
-	-	-		% of modern contraceptives and associated supplies available at each health facility	Facility checklist
-	-	-		• % of HFs have clinical protocols and guidelines in family planning available	Facility Checklist
4	-	-	Understanding of the specific situation of the newborn, maternal health care and family planning services and barriers has been achieved		Baseline assessment reports, work plans, monitoring tools and final evaluation report
-	-	-			Reproductive health survey completed in selected sites

Annex 2: Maps of Cameroon, Chad, and Niger



UNHCR Niger | Population of concern 30 - Avril - 2020



Annex 3: Evaluation Matrix

EVALUATION QUESTIONS & OBJECTIVES OECD CRITERIA	INDICATORS FOR EVALUATION	DATA SOURCES	ANALYTICAL APPROACHES
AREA 1: DESIGN (MODEL AND STRATEGY)			
KEQ 1: To what extent is the 2018-2019 BMGF project design relevant to achieve its intended goal and objectives of saving maternal and newborn lives in refugee camps/settlements in Cameroon, Chad and Niger?			
SUQ 1.1. To what extent were baseline assessment findings identifying population needs and how were they incorporated in the project design? [RELEVANCE]	Extent of alignment to population needs and baseline assessment Extent of alignment with BMGF SRH objectives, level of innovation, implications for resources	KIIs UNHCR and stakeholder project documentation, and policy guidance	Triangulation between data sources and across stakeholder groups
SUQ 1.2. How could the project design and the choice of activities be strengthened to improve its relevance to reaching the goal of the project? [RELEVANCE]	Gaps/limitations in the design of the project Extent of adaptability of the project (pos and neg) as a result of the context (COVID-19 or other contextual factors)	Logical framework Baseline assessments	Logical framework analysis
SUQ 1.3. To what extent have partners been able to adapt the project design to contextual changes in order to maintain the project relevance? [RELEVANCE] [COHERENCE]			

AREA 2: IMPLEMENTATION (INPUTS, OUTPUTS, PROCESSES AND PARTNERSHIPS)			
KEQ 2: How successfully have the projects been operationalized? To what extent was the project implementation in each country delivered as intended in the following areas: capacity building of care providers, health facility strengthening, comprehensive maternal and newborn care packages (including low cost-high impact activities), comprehensive family planning services, good practices and guidance to improve care?			
SUQ 2.1. To what extent did the organisational set-up of the project (processes, systems, and tools) contribute to effective implementation?	Activities are delivered according to plans, budgets and expenditures (inputs =>outputs)	KIIs Project Documentation and budget and expenditure data	Triangulation between data sources and across stakeholder groups

[EFFECTIVENESS]	Nature and extent of partnership / engagement arrangements with implementing actors	M&E data Stakeholder mapping	M&E data analysis ²⁶
SUQ 2.2. What were the major factors influencing (positive or not) the implementation of the project? [EFFECTIVENESS]	Extent of adaptability of the project (pos and neg) Gaps/limitations in the implementation of the project Nature and extent of the support to PHO's Changes in funding availability due to reprioritization by Country Office (CO)	KIIs Project Documentation Stakeholder mapping Budget and expenditure data	Triangulation between data sources and across stakeholder groups
SUB 2.3. Did implementation vary across countries/programs/context? [EFFECTIVENESS] [COHERENCE]	Extent of variability in implementation outputs and budget, expenditures and the contributing factors Level of systematization / standardization in implementation	KIIs Project Documentation Broad budget and expenditure lines	Triangulation Cross country analysis

²⁶ As per Annex 1 indicators

<p>SUQ 2.4. Which enabling and challenging factors, if any, should be taken into account in future MNH programming for existing operations and new interventions, bearing in mind constrained budgets and both a) normal circumstances, b) COVID-19 context and c) change processes in UNHCR?</p> <p>[EFFECTIVENESS] [COHERENCE]</p>	<p>Contextual challenges that affected activities</p> <p>Promising practices in the implementation of the project</p> <p>Nature and extent of support to the PHO's</p> <p>New Resource Allocation Framework and ability to absorb private sector funding</p> <p>Prioritization of the project by the CO in annual plans and budgets in the new multiyear program planning and budgeting and results framework</p>	<p>KIIs</p> <p>Project Documentation</p> <p>Stakeholder mapping</p>	<p>Co-creation sessions on findings, lesson learnt and recommendations</p>
<p>KEQ 3: What were the budgeted and expenditure levels of implementing key components of the project and the project across the three contexts?</p>			
<p>SUQ 3.1. Were output targets met in line with the planned budget?</p> <p>[EFFICIENCY]</p>	<p>Output targets are met in line with allocated budget</p> <p>Budget gaps</p> <p>Budget flexibility</p>	<p>KIIs</p> <p>Financial/expenditure data</p> <p>HIS/M&E data (incl. safe abortion care)</p>	<p>Expenditure analysis</p> <p>M&E indicator review</p>
<p>SUQ 3.2. What were the main drivers of expenditures and budget prioritization? Did this vary by context / programs / country?</p> <p>[EFFICIENCY]</p>	<p>Extent of Low cost-high impact activities</p> <p>Extent of flexibility in budget expenditure</p> <p>Extent of accelerated access to funds</p>	<p>KIIs</p> <p>Financial/expenditure data</p> <p>HIS/M&E data</p>	<p>Expenditure analysis</p> <p>Cross country analysis</p>

AREA 3: PERFORMANCE (RESULTS, OUTPUTS, OUTCOMES, SUSTAINABILITY AND ACCOUNTABILITY)

KEQ 4: To what extent did the project reduce maternal and neonatal mortality and morbidity and what were the major factors that influenced changes in mortality and morbidity in targeted populations?

<p>SUQ 4.1. To what extent did the community-based interventions contribute to the project objectives and ensure a continuum of care? [EFFECTIVENESS]</p>	<p>Extent of outputs resulting in or contributing to outcomes for community-based care Budget allocation</p>	<p>KIIs Project Documentation HIS/M&E data</p>	<p>Triangulation between data sources and across stakeholder groups</p>
<p>SUB 4.2. To what extent did the project increase contraceptive uptake and contribute to the project objectives? [EFFECTIVENESS]</p>	<p>Extent of outputs resulting in or contributing to outcomes for FP Budget allocation</p>	<p>KIIs Project Documentation HIS/M&E data</p>	<p>Triangulation between data sources and across stakeholder groups</p>
<p>SUB 4.3. To what extent did Capacity Building activities contribute to the project objectives? [EFFECTIVENESS]</p>	<p>Extent of outputs resulting in or contributing to outcomes for CB Budget allocation</p>	<p>KIIs Project Documentation HIS/M&E data</p>	<p>Triangulation</p>
<p>SUB 4.4. Did results vary across countries/programs/context? And what were contributing factors? [EFFECTIVENESS]</p>	<p>Extent of variety in outcomes Budget allocation variety</p>	<p>KIIs Project Documentation HIS/M&E data</p>	<p>Triangulation Cross country analysis</p>
<p>SUQ 4.5. To what extent were important project consequences (pos and neg) noted since the emergence of COVID-19? [EFFECTIVENESS]</p>	<p>Extent of project flexibility/adaptability in activities and budget</p>	<p>KIIs Project Documentation HIS/M&E data Budget</p>	<p>Triangulation between data sources and across stakeholder groups Cross country analysis</p>

KEQ 5: To what extent does the project demonstrate: (a) sustainability in terms of the continuation of key activities and results in each country; and (b) successful institutionalization in the UNHCR public health global efforts?

<p>SUQ 5.1. To what extent are the project results likely to be sustained?</p>	<p>Sustainability aspects embedded in local health care program (e.g., capacity building, quality of care, monitoring)</p> <p>Non-UNHCR/BMGF sources of funding are available</p>	<p>KIIs</p> <p>Program/project Documentation</p>	<p>Triangulation between data sources and across stakeholder groups</p> <p>Cross country analysis</p>
<p>SUQ 5.2. What are the major factors affecting the sustainability (programmatic and financial sustainability) of activities and results achieved in each country?</p>	<p>Overview of sustainability aspects embedded in program (exit strategies/transition plans/handover/supply/HR turnover)</p> <p>Overview of short- and long-term training outcomes</p>	<p>KIIs</p> <p>Program & Project Documentation</p>	<p>Triangulation between data sources and across stakeholder groups</p> <p>Cross country analysis</p>
<p>SUQ 5.3. What support will potentially remain necessary to maintain activities and results, and/or to complement any element identified as missing or insufficient in each context?</p>	<p>HCR/BMGF sources of funding</p> <p>Extent of expenditure flexibility</p>	<p>KIIs</p> <p>Program & Project Documentation</p> <p>Funding/grant agreements</p>	<p>Triangulation between data sources and across stakeholder groups</p> <p>Cross country analysis</p>
<p>SUQ 5.4. To what extent has UNHCR institutionalized successfully the learnings from the BMGF funded project approaches into their public health work globally? What other actions could UNHCR take to better incorporate learning from this project into their public health programming globally?</p>	<p>Lessons learned analysis</p> <p>Overview of old and new strategy document, guidance and monitoring tools for dissemination</p>	<p>KIIs</p> <p>Dissemination matrix</p> <p>Online tools</p> <p>Documentation on UNHCR commitments to learning</p>	<p>Triangulation</p>

KEQ 6: To what extent is the PHS-PSP-BMGF partnership strategic and being cultivated to generate value for both UNHCR and BMGF?

<p>SUB 6.1 What are indispensable for the PHS in order to be able to adequately program in order to meet the requirements and expectations of BMGF, and what does PSP need in order to cultivate the relationship with Gates and other similar private sector donors?</p>	<p>Key enabling and inhibiting conditions of UNHCR's planning, programming and budgeting that affected achievement of the grant goals funded by BMGF.</p> <p>Necessary preconditions for securing long-term, flexible funding from BMGF (from Emergency fund & MNH).</p> <p>Per capita health benchmark for each country</p>	<p>KIIs</p> <p>Program documentation</p> <p>UNHCR Manual-operation management cycle</p> <p>Funding/grant agreements</p>	<p>Co-creation sessions on findings, lesson learnt and recommendations</p> <p>Synthesis analysis and triangulation</p>
<p>SUB 6.2 How could these conditions be established or strengthened to better cultivate and optimize these types of partnerships in the future, at global and regional levels?</p>	<p>Extent of expenditure, funding flexibility, equitability, and prioritization</p> <p>Provision of a Minimal budget per capita</p> <p>Provision of a minimal population health budget for a SRH package</p> <p>Overview of BMGF expected alignment</p>	<p>Results of EQ1, EQ 6.1</p> <p>KIIs</p> <p>Funding/grant agreements and policy guidance</p> <p>Comparative budget documents (e.g., Uganda)</p>	<p>Co-creation sessions on findings, lesson learnt and recommendations</p> <p>Synthesis and triangulation</p>

Annex 4: Documents Reviewed

Key UNHCR Documents:

Expansion of the Saving Maternal and Newborn Lives in Refugee Settings Project (Cameroon, Niger, Chad): Summary of Baseline Assessment

UNHCR Global Health Strategy for Public Health

UNHCR Evaluation Strategy 2018-2022

Long-term Strategy for Public Health - BMGF

UNHCR 2020 Evaluation Inception Report

Country Reports:

Interim report for the Expansion of the Saving Newborn Lives in Refugee Situations Project (2020)

October 2019 (April-June, Sept 2019) Cameroon Monitoring visit

October -December 2019 Cameroon Monitoring visit

BMGF interim report January – December 2020

Interim report for the Expansion of the Saving Newborn Lives in Refugee Situations Project (2020)

BMGF Chad interim report January - December 2020

March 2019(Oct-Dec 2018, Feb 2019 field visits) Chad Monitoring Report

April-June 2019 Chad Monitoring Report

July-Sept 2019 Chad Monitoring Report

Niger Monitoring Report 02 2019

Interim report for the Expansion of the Saving Newborn Lives in Refugee Situations Project (2020)

Niger 2020 Gates Project Report

External Documents:

BMGF Maternal, Newborn & Child Health (<https://www.gatesfoundation.org/our-work/programs/global-development/maternal-newborn-and-child-health>)

BMGF Emergency Response (<https://www.gatesfoundation.org/our-work/programs/global-development/emergency-response>)

WHO: Standards for improving quality of maternal and newborn care in health facilities, 2016 (https://www.who.int/maternal_child_adolescent/documents/improving-maternal-newborn-care-quality/en/)?

WHO: Monitoring the building blocks of health systems: A handbook of indicators and their measurement strategies (https://www.who.int/healthinfo/systems/WHO_MBHSS_2010_full_web.pdf)?

Annex 5: Key Stakeholders Interviewed

<i>Location</i>	<i>Organization/Unit</i>	<i>Position/Role</i>	<i>Number</i>	
<i>BMGF</i>	EMR	Deputy Director	1	
<i>UNHCR HQ</i>	PHS	Chief of Section	1	
		BMGF Project Manager	1	
	PSP	Former & current RH & HIV Officer	2	
		Former PSO Officer	1	
		Chief of Section	1	
		Senior PSP Officer	1	
	DRS/DPSM	Director DRS	1	
		Dep Dir Operation Services	1	
	Evaluation Unit	Sr. Evaluation Officer	1	
	<i>UNHCR</i>	Regional Office Western Africa	Sr. PHO	1
Sr. Evaluation Officer			1	
<i>Chad</i>	UNHCR-Capital	Sr. PHO	1	
		National PHO	1	
		MoH Director of Reproductive Health	1	
	Project & Field Office	Assoc. Public health officer	2	
		Head of Field Office	1	
	IRC	Medical Coordinator	2	
	CSSI	Medical Coordinator	1	
	MoH	Beneficiary	1	
	<i>Cameroon</i>	UNHCR-Capital	Country & Deputy Representatives	2
			PH Nutrition Officer	1
LDHF Training Consultant (for all 3 countries)			1	
Project & Field Office		IMC Medical Coordinator Nord	1	
		Head of sub-Office	1	
		PHOs	2	
		Medical Coordinators	2	
		Partner Coordination Staff	1	
		Coordinatrice Volet Communautaire	1	
		Point Focal Projet Gates	1	
MoH		SF Hôpital de District	1	
		Beneficiary	1	
<i>Niger</i>		UNHCR-Capital	PHO	1
	APBE Partner		1	
	Project & Branch Office	Public Health/Nutrition Associate	1	
		Medical Coordinators	1	
		Director CSME	1	
		Beneficiary	1	
		Total	44	

Annex 6: Interview Questions

Introduction	
	Please introduce yourself briefly including your background, job title, organisation, role and how it relates to UNHCR.
0.1	Probe: how long have you been in this role? What are your key areas of responsibility? Main area of focus? CSO-Tell me about your organization and how you work with refugees in this camp/area? What kinds of refugees do you reach out to and why?
0.2	What interactions or specific activities have you had with UNHCR? (program management, funding, SRH, capacity building activities or other)? CSO—What interactions, if any, have you had with [INSERT NAME of Implementing partner]?
AREA 1 – PROJECT DESIGN / MODEL / STRATEGY	
1	To what extent is the 2018-2019 BMGF project design relevant to achieve its intended goal and objectives of saving newborn and maternal lives in Cameroon, Chad and Niger? Probes: -are activities the right activities for improving maternal and neonatal health? -are there important activities missing from the package? -How well did the activities complement what you were already doing? -what were gaps/limitations in the design of the project? [for BMGF only] -To what extent are the “Saving maternal and newborn lives in refugee situations” project aligned with BMGF SRH objectives? -To what extent does HCR level of innovation match BMGF expectations? Can you give some examples what is/what’s not included?
1.1	To what extent did baseline assessment outcomes identifying population needs and how were they incorporated in the project design? Probes: How were population needs assessed? What were the main population needs identified? Can you give some examples where population needs/demand were incorporated in the design?
1.2	How could the project design and the choice of activities be strengthened to improve its relevance to reaching the goal of the project?
1.3	What contextual changes took place during the lifetime of this project and to what extent have partners been able to adapt the project design to those changes to maintain project relevance? Probes: Insecurity? Problems of access? Did the project incur significant adjustments due to COVID-19? Would you give some examples? What was done to revert/adjust this? (HR, finance, activities...)

	AREA 2: IMPLEMENTATION (INPUTS, OUTPUTS, PROCESSES AND PARTNERSHIPS)
	Moving now to the implementation of the project
2	<p>How successfully has the project been operationalized or implemented?</p> <p>Was the project delivered as intended in general? Was the project delivered in the following areas: capacity building of care providers, health facility strengthening, comprehensive maternal and newborn care packages (including low cost-high impact activities), comprehensive family planning services, good practices and guidance to improve care? Can you think of activities that didn't go as planned? And why? How effectively did the community based/training activities work?</p>
2.1	<p>To what extent did the organisational set-up of the project (processes, systems, tools) contribute to effective implementation?</p> <p>Which systems can be strengthened to improve implementation? Probes: Sufficient and qualified HR? PHOs? Administrative procedures enabling/disabling implementation? Logical set up and support? Supply of medical equipment/drugs? Nature of the partnership between UNHCR and IPs? Implications of MoH? Monitoring system of HCR and IPs?</p>
2.2	<p>What were the major factors influencing (positive or not) the implementation of the project? Probes: Resources like HR, finance, logistics? Contextual factors like infrastructure, access? Support to IPs?</p>
2.3	<p>How did implementation vary across the 3 countries? Why?</p> <p>What were cross country differences in inputs/outputs/processes? Can you give some specific examples?</p> <p>What were contributing factors? Can the approach and learnings from this project inform future guidance and support to relevant UNHCR preparations and action for MNH? Why? Why not? Which factors need to be taken into account for a roll out globally? Probes: Resources: HR, finance, administration? Contextual factor? The choice of implementing partner and its capacity?</p>

	To what extent was budget amount/prioritisation and flexibility different across the countries?
2.4	<p>Which enabling and challenging factors, if any, should be taken into account in future MNH programming for existing operations and new intervention bearing in mind constrained budgets in both:</p> <p>a) normal circumstances b) COVID-19 context?</p> <p>Probe: How to sustain low-cost high impact activities?</p>
3	What were the budgeted and expenditure levels of implementing key components of the project and the project across the three contexts? Does it vary across implementing partners?
3.1	<p>Were output targets met in line with the (planned time) and budget?</p> <p>Can you give some examples where budget was short for activities? How were shortages managed?</p> <p>What were gaps in timely implementation? What contributed to these gaps?</p>
3.2	<p>What were the main drivers of expenditures and budget prioritization? Did this vary by context/programs/country?</p> <p>Are funding arrangements sufficiently responsive to the needs of the project?</p> <p>If not, why – please give a specific example of where e.g., a delay/prioritisation/flexibility in release of funds prevented or delayed an activity from taking place?</p> <p>Did the budget allow sufficient capacity to implement the full scope of work? If not, can you give an example?</p> <p>Probe: Budget flexibility/prioritisation/amount/delays?</p>
	AREA 3: PERFORMANCE (RESULTS, OUTPUTS, OUTCOMES, SUSTAINABILITY AND ACCOUNTABILITY)
	Moving now to performance, and results

4	<p>Broadly speaking, to what extent did the project reduce maternal and neonatal mortality and morbidity?</p> <p>What were the major factors that influenced changes in mortality and morbidity in targeted populations? Any gaps/differences in who benefited?</p> <p>Probes: ...HR, community-based care, capacity building, low input high frequency trainings, supply, health facility strengthening, low cost-high impact SRH activities, comprehensive family planning services, population movement, arrival of new (related) actors, natural disaster, change in conflict dynamics...?</p>
4.1	<p>To what extent did the community-based interventions/activities contribute to the project objectives and ensure a continuum of care?</p> <p>If it did, how so? Could you demonstrate this with examples? What were factors that enabled/disabled this continuum? What steps can be taken to maximise this continuum?</p>
4.2	<p>To what extent did the project increase contraceptive uptake and contribute to the project objectives?</p> <p>If it did, how did it? Would you demonstrate this with examples? What were factors that enabled/disabled this FP increase? What steps can be taken to maximise FP?</p>
4.3	<p>To what extent did Capacity Building (CB) activities contribute to the project objectives?</p> <p>If it did, how did it? Can you demonstrate this with examples? What were factors that enabled/disabled CB? What steps can be taken to maximise CB? CSO—how does the community perceive the work of the implementing partner? Are there aspects of their work that you think/heard need improvement?</p>
4.4	<p>Did results vary across countries/programs/context?</p> <p>What were contributing factors?</p> <p>Could you give any specific examples of where, when and how?</p>
4.5	<p>To what extent were important program consequences (pos and neg) noted since the emergence of COVID-19 and on whom (any specific sub-populations who were affected)?</p> <p>What Covid-19 contextual factors affected the achievement of the project results/outcomes? Any examples?</p>

	<p>Probe for examples: Resources/supply/infrastructure not ensuring safety? Patients avoiding health facilities due to fear of COVID infection? Lack of innovations/ tools/resources to continue the activities as normal? Team/expertise/experience wasn't COVID appropriate?</p>
	Moving now to sustainability
5	<p>To what extent does the project demonstrate sustainability in terms of the continuation of key activities and results in each country? Or To what extent are UNHCR results likely to be sustained? If so, which results are you thinking of? And among which subpopulations, why?</p>
5.1	<p>What project activities will be maintained as part of routine program activities in primary healthcare after the end of the project?</p>
5.2	<p>What are the major factors affecting the sustainability of activities and results achieved in each country? Programmatic sustainability? Can you give some examples and why? Financial sustainability? Can you give some examples and why? Probes: Examples of exit/transition plans/handover? Examples of linkages to national MoH SRH structures? Examples of training outcomes?</p>
5.3	<p>What support will potentially remain necessary to maintain activities and results, and/or to complement any element identified as missing or insufficient in each context? How could chances for sustainability of UNHCR outcomes be improved?</p>
5.4	<p>To what extent has UNHCR institutionalized successful the learnings from the BMGF funded project approaches into their public health work globally (including monitoring system, assessment tools, HIS, etc.)? Can you give some examples? Are there any other emerging good practices from this project in your opinion? What other actions could UNHCR take to better incorporate learning from this project into their public health programming globally?</p>

6	<p>To what extent is the PHS-PSP-BMGF partnership to result in long term collaborations? What role, if any, should the Regional Bureau have in this partnership in the future?</p> <p>What are preconditions/factors to positively influence the future partnership?</p> <p>Which elements can be improved in relation to communication? Collaboration? Coordination? Accountability? Transparency & results sharing? How the different stakeholders internally support the partnership with the BMGF and future private sector partnerships?</p>
6.1	<p>What are indispensable elements for the PHS in order to be able to adequately program and manage its partnership with Gates and other donors?</p> <p>Probes: Collaboration / Coordination? Communication & Reporting/results sharing? Accountability & transparency? Innovation?</p>
6.2	<p>What factors enable/hinder its efforts that would need to be strengthened to better leverage these partnerships in the future? (internally – roles and responsibilities, working relationships between PSP, PSH, regional bureaux and country offices)</p> <p>Probes: Collaboration / Coordination Communication & Reporting/results sharing? Accountability & transparency? Innovation?</p>

Annex 7: Additional Project Results Tables & Figures

A. Summary indicators Cameroon, Chad and Niger – 2018-2020

Indicators Cameroon, Chad and Niger – 2018-2020

	Baseline	Target	2018 Q4	2019 Q1	Q2	Q3	Q4	2020 Q1	Q2	Q3
Stillbirth rate (on 1000 births)										
Cameroon	28,3	22,6	27,4	53,7	44,4	38,3	24,6	29,9	19,9	38,4
Chad	18,5	14,8	31,3	19,3	33,6	27,2	26,2	30,1	26,7	29,0
Niger	23,0	18,4	24,7	36,2	18,9	32,1	42,3	27,4	28,2	32,8
Neonatal mortality rate neonatal deaths per 1000 live births										
Cameroon	10,8	8,1	15,6	28,8	28,9	21,9	6,1	4,9	9,6	19,9
Chad	4,1	3,1	23,8	17,6	23,7	13,7	10,8	7,9	13,5	9,8
Niger	2,9	2,2	22,2	9,4	2,1	2,1	4,2	0,0	25,8	46,2
Total number of maternal deaths										
Cameroon	1,8	NA	1,0	1,0	4,0	2,0	2,0	0,0	1,0	2,0
Chad	0,0	NA	4,0	1,0	6,0	0,0	3,0	5,0	7,0	0,0
Niger	1,0	NA	0,0	0,0	0,0	1,0	0,0	1,0	2,0	0,0
BEmONC signal functions performed (out of 7)										
Cameroon	5,0	6,0	3,1	4,7	4,9	4,3	4,4	3,9	4,6	4,2
Chad	5,3	6,0	3,8	4,4	5,1	4,5	5,0	5,5	4,7	4,4
Niger	6,0	6,0	3,3	3,3	4,4	4,4	4,2	3,7	4,7	3,7
Bag and mask ready at each delivery										
Cameroon	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Chad	35%	100%	38%	88%	86%	100%	100%	NA	NA	NA
Niger	100%	100%	75%	100%	100%	100%	100%	100%	100%	100%
% de bébés < 2000 g using KMC										
Cameroon	NA	65%	53%	87%	95%	78%	90%	100%	99%	86%

Chad	NA	65%	0%	64%	55%	100%	96%	100%	100%	98%
Niger	NA	65%	0%	100%	100%	100%	100%	100%	100%	NA
% KMC wraps available										
Cameroon	0%	80%	67%	100%	100%	100%	100%	100%	89%	100%
Chad	0%	80%	0%	80%	71%	75%	79%	100%	100%	100%
Niger	0%	80%	0%	33%	40%	100%	80%	100%	100%	100%
% of clinical SRH and HIV guides available										
Cameroon	60%	100%	89%	96%	100%	100%	100%	100%	100%	100%
Chad	13%	100%	61%	99%	94%	88%	95%	94%	94%	94%
Niger	48%	100%	77%	82%	84%	96%	95%	97%	97%	97%
Percentage of essential equipment for childbirth care available										
Cameroon	80%	90%	86%	96%	95%	93%	92%	92%	96%	95%
Chad	69%	90%	67%	84%	83%	89%	89%	87%	87%	85%
Niger	77%	90%	83%	86%	80%	94%	94%	99%	99%	99%
Percentage of essential medications for childbirth care available										
Cameroon	71%	90%	73%	82%	85%	83%	81%	77%	84%	86%
Chad	68%	90%	67%	81%	69%	88%	79%	86%	75%	72%
Niger	72%	90%	90%	85%	87%	80%	94%	97%	97%	98%
FP clinical guidelines available										
Cameroon	45%	100%	100%	100%	89%	89%	100%	100%	100%	100%
Chad	40%	100%	71%	80%	79%	77%	71%	80%	87%	80%
Niger	14%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Percentage of modern contraceptives and associated supplies available										
Cameroon	70%	100%	81%	88%	87%	90%	84%	86%	88%	87%
Chad	66%	100%	67%	82%	79%	87%	84%	83%	82%	80%
Niger	75%	100%	88%	92%	87%	93%	95%	94%	94%	94%
Total number of new users of modern contraceptives										

Cameroon	NA	412	343	225	207	154	510	231	150	289
Chad	NA	1925	1604	825	2071	1368	1778	2451	2809	2651
Niger	NA	253	211	263	546	280	454	313	204	233
Number of different types of contraceptives used										
Cameroon	NA		3,4	2,3	3,2	2,7	3,1	2,4	2,2	2,9
Chad	NA		3,6	2,9	4,5	4,3	5,1	5,0	5,2	4,9
Niger	NA		3,8	3,4	4,2	4,8	5,6	3,0	2,6	2,8
Total number of births										
Cameroon	NA		1385	950	833	913	1016	836	955	938
Chad	NA		1821	1449	1967	1877	2098	2096	2057	2000
Niger	NA		324	221	477	498	497	329	319	427
Live births										
Cameroon	NA		1344	904	796	868	991	811	936	904
Chad	NA		1764	1421	1900	1824	2043	2033	2002	1942
Niger	NA		316	213	468	482	476	320	310	411
Fresh Stillbirths										
Cameroon	NA		21	26	15	19	16	13	10	23
Chad	NA		28	17	32	21	21	37	25	34
Niger	NA		2	6	3	4	7	1	2	4
Macerated Stillbirths										
Cameroon	NA		17	25	22	16	9	12	9	13
Chad	NA		30	11	34	28	34	26	30	24
Niger	NA		6	2	5	12	14	8	7	10
Total stillbirths										
Cameroon	NA		38	51	37	35	25	25	19	36
Chad	NA		57	28	66	51	55	63	55	58
Niger	NA		8	8	9	16	21	9	9	14
Neonatal case fatality rate										

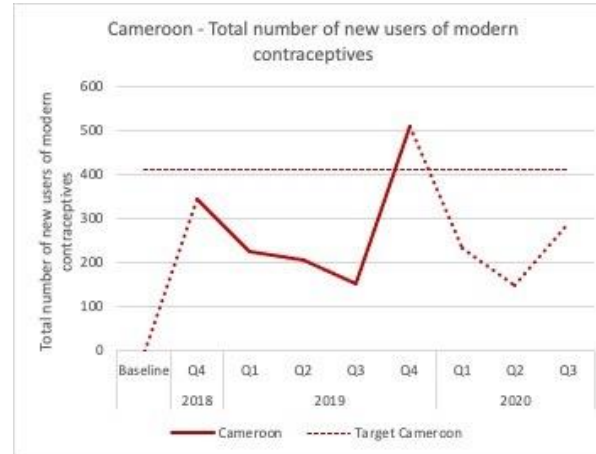
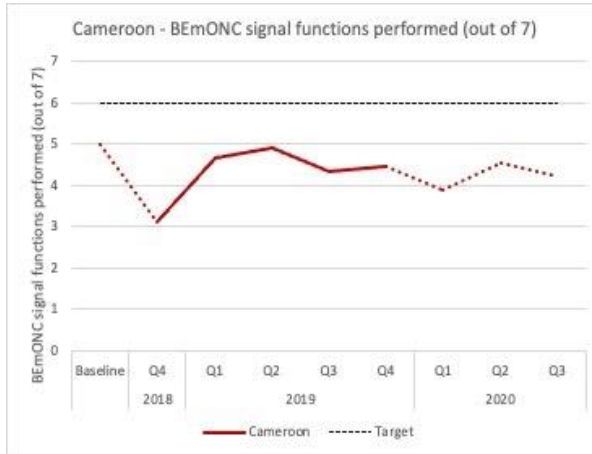
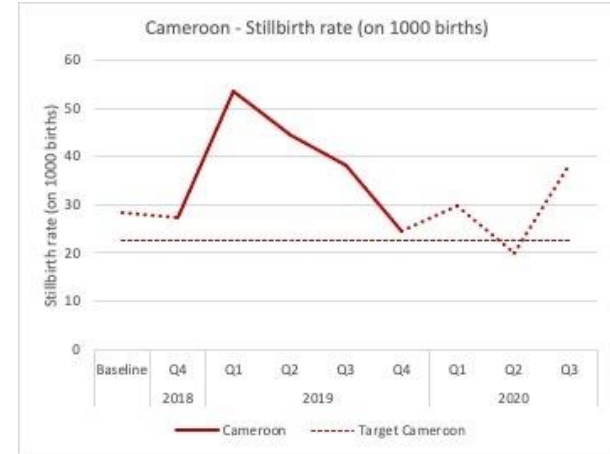
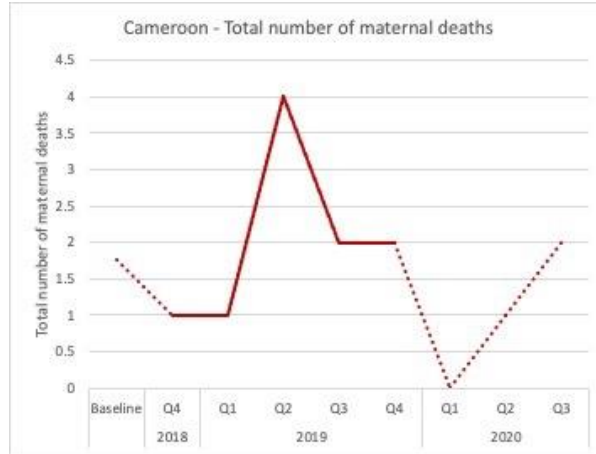
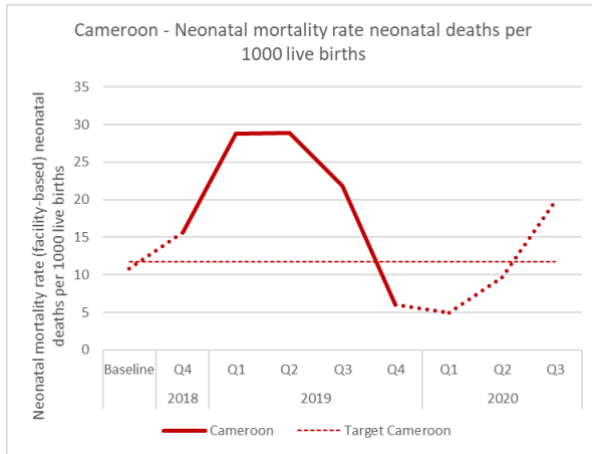
Cameroon	NA	8%	9%	10%	9%	3%	2%	4%	9%
Chad	NA	26%	19%	19%	17%	13%	7%	11%	8%
Niger	NA	19%	40%	4%	2%	3%	0%	11%	33%

B. Summary Results Framework Indicators Cameroon

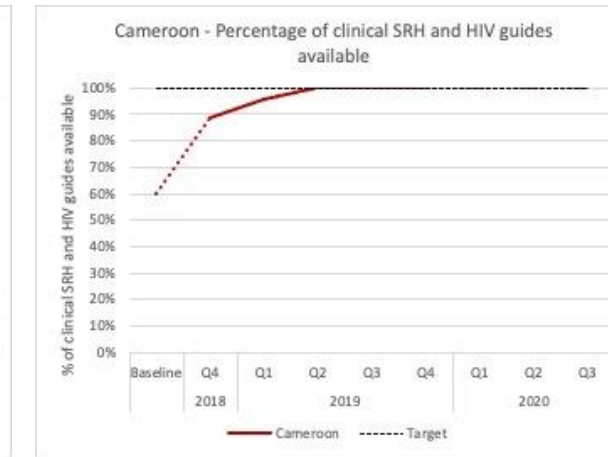
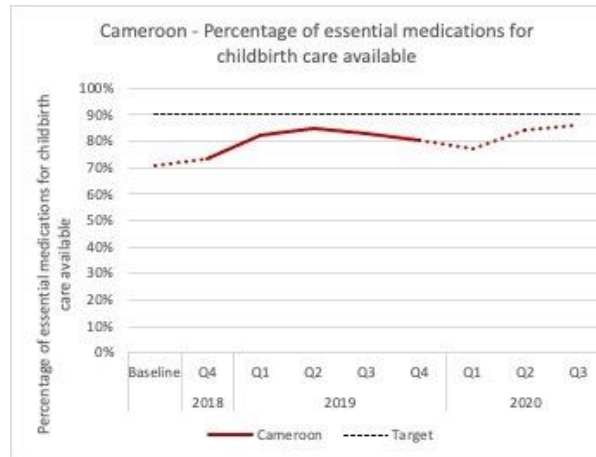
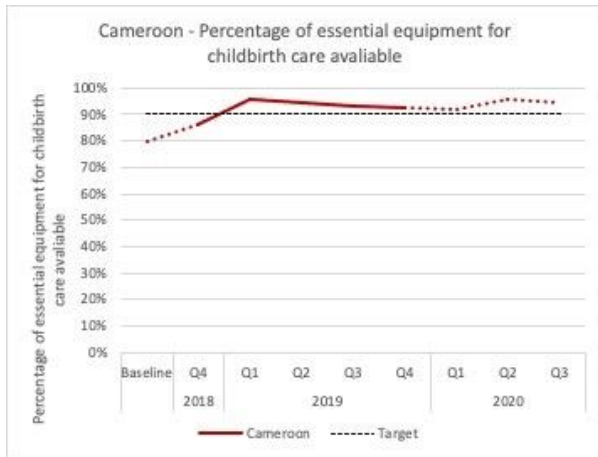
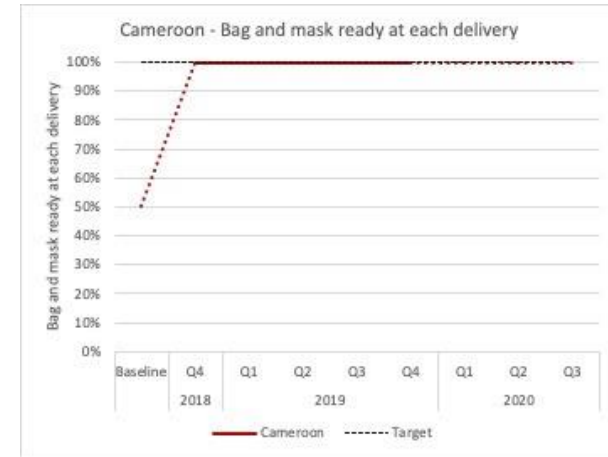
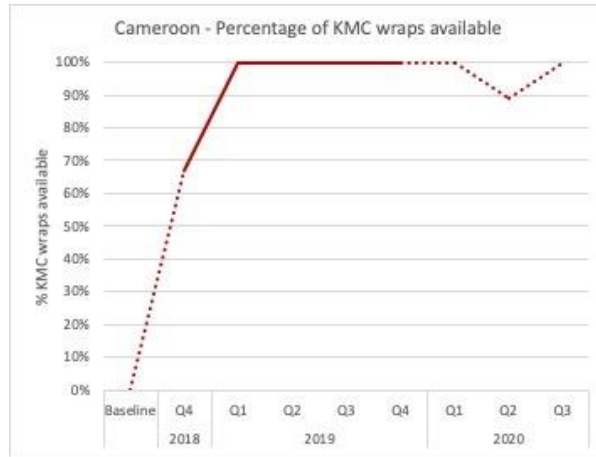
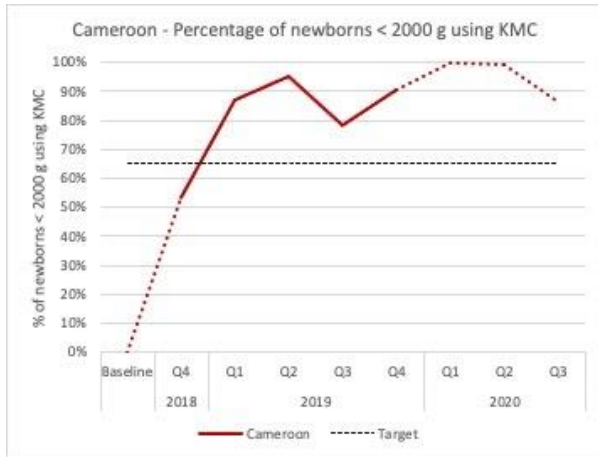
		Baseline	Target	Results								
				2018			2019			2020		
Cameroon				Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	
1	Quality, comprehensive essential newborn health care provided	NMR (number of neonatal deaths per 1000 live births)	10,8	(8,1)	15,6	28,8	28,9	21,9	6,1	4,9	9,6	19,9
1.1	Capacity of health providers and community-based health workers on essential new-born interventions strengthened	Number and % of health providers trained in essential newborn care	29%	100%						58%		
		Number and % of CHWs trained in essential newborn care	97%	100%						60%		
		% of health facilities providing KMC	60%	65%	89%					100%		
		% of babies < 2000 g placed in KMC	NA	65%	53%	87%	95%	78%	90%	100%	99%	86%
1.2	Adequate new-born supplies, equipment and guidelines/protocols to health clinics have been provided	% of health facilities with functioning newborn bag and mask available	50%	100%	100%	100%	100%	100%	100%	100%	100%	100%
		% of HFs with KMC wraps available	0%	80%	67%	100%	100%	100%	100%	100%	89%	100%
2	Quality comprehensive maternal health services improved	Maternal mortality (crude numbers)	1,75	NA	1	1	4	2	2	0	1	2
		Stillbirth rate per camp/site (number of stillbirths per 1000 live and stillbirths)	28,3	22,64	27,4	53,7	44,4	38,3	24,6	29,9	19,9	38,4
		Average number of 7 signal BEmONC functions performed in the past 3 months	5	6,5	3,1	4,7	4,9	4,3	4,4	3,9	4,6	4,2
2.1	Capacity building of human resources: training of the health providers on routine and emergency obstetric care	Number and % of qualified health providers trained on routine and emergency obstetrics	36%	100%								(North 100%)

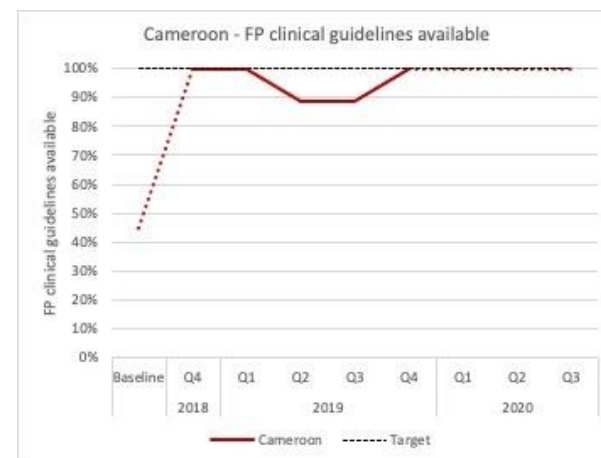
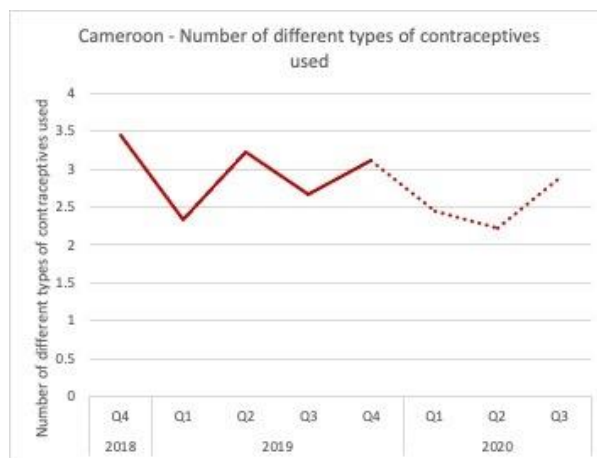
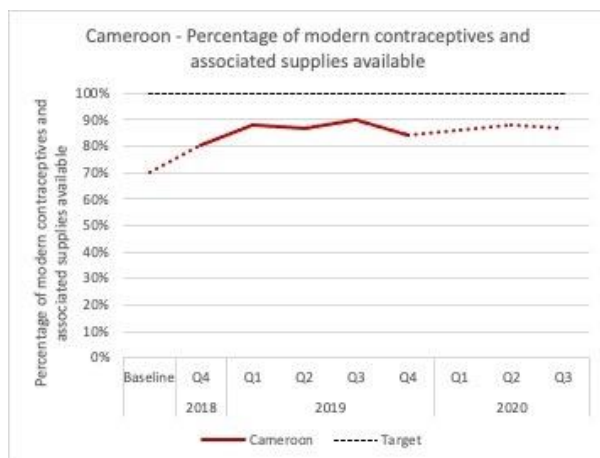
												East 55%)
2.2	Adequate maternal supplies, equipment and guidelines/protocols provided to health clinics have been provided	% of essential equipment for childbirth care available in each health facility	80%	90%	86%	96%	95%	93%	92%	92%	96%	95%
		% of essential medications for childbirth care available in each health facility	71%	90%	73%	82%	85%	83%	81%	77%	84%	86%
		% of HFs have clinical protocols and guidelines available (*detailed reproductive health and HIV guidelines BSC-RH)	60%	100%	89%	96%	100%	100%	100%	100%	100%	100%
3	Quality comprehensive family planning services improved	<i>Contraceptive Prevalence Rate</i>	NA	NA	NA							
		Number of new users of modern contraceptive methods	343	412	343	225	207	154	510	231	150	289
3.1	Capacity building of human resources: training of the health providers and community-based health workers on contraceptive counselling, contraceptive modern methods and sensitization and promotion strategies strengthen	Number and % of qualified health providers (doctors and midwives) trained on contraceptives methods and counselling	15%	100%					100%			
3.2	Adequate contraceptive maternal supplies, equipment and guidelines/protocols provided to health clinics have been provided	Nb of modern contraceptives methods provided by health facility to clients over the last 3 months	NA		3,4	2,3	3,2	2,7	3,1	2,4	2,2	2,9
		% of modern contraceptives and associated supplies available at each health facility	66%	100%	81%	88%	87%	90%	84%	86%	88%	87%
		% of HFs have clinical protocols and guidelines in family planning available	45%	100%	100%	100%	89%	89%	100%	100%	100%	100%
4	Understanding of the specific situation of the new-born, maternal health care and family planning services and barriers has been achieved	Baseline assessment conducted	NA	NA	Done							

Cameroon Outcome Indicators – Figures



Cameroon Output Indicators





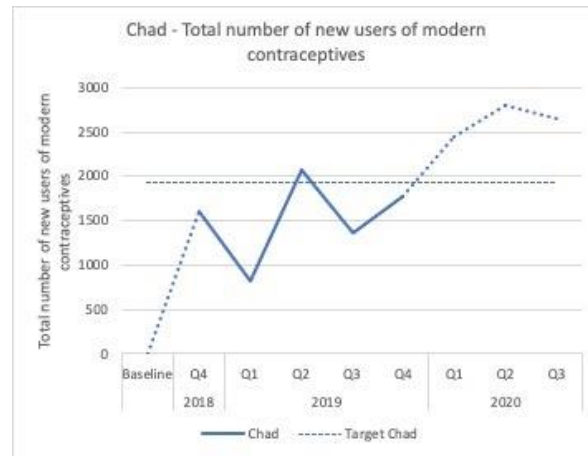
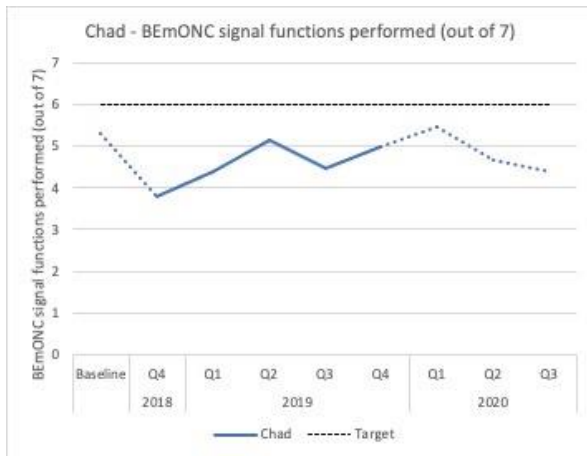
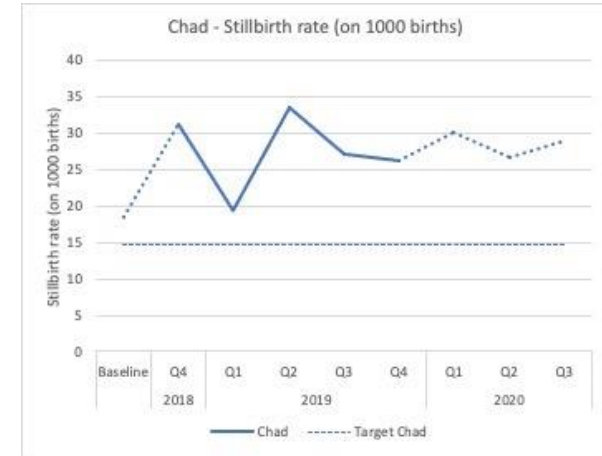
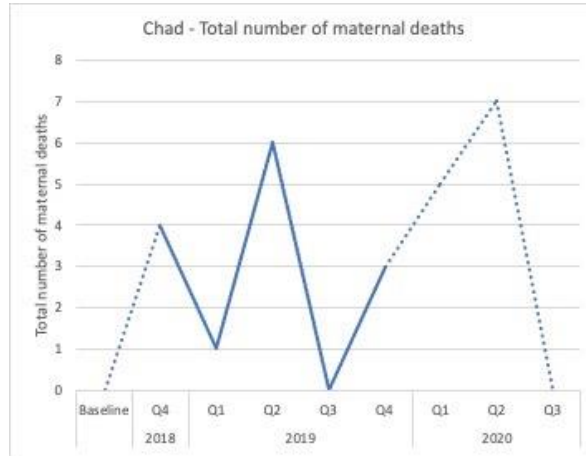
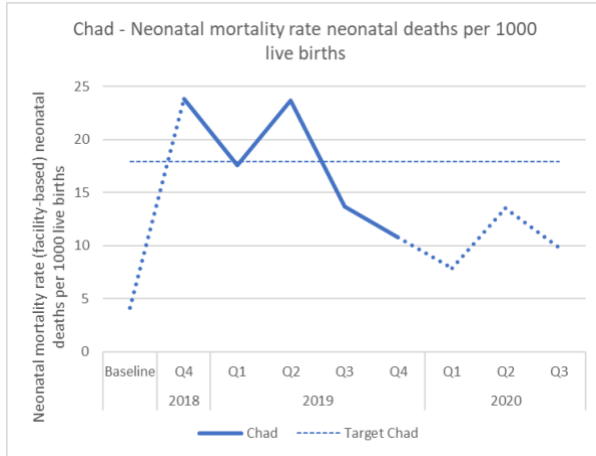
C. Summary Results Framework Indicators - Chad

		Baseline	Target	Results								
				2018	2019			2020				
Chad				Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	
1	Quality, comprehensive essential newborn health care provided	NMR (number of neonatal deaths per 1000 live births)	4,1	(3,1)	23,8	17,6	23,7	13,7	10,8	7,9	13,5	9,8
1.1	Capacity of health providers and community-based health workers on essential new-born interventions strengthened	Number and % of health providers trained in essential newborn care	33%	100%				61%				
		Number and % of CHWs trained in essential newborn care	50%	100%				80%				
		% of health facilities providing KMC	41%	65%	0%			100%				
		% of babies < 2000 g placed in KMC	NA	65%	0%	64%	55%	100%	96%	100%	100%	98%

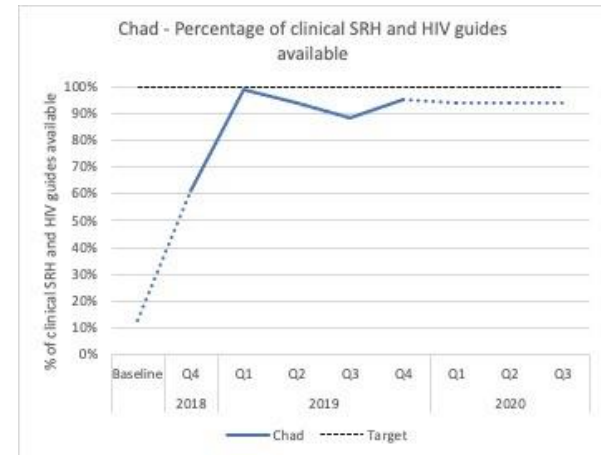
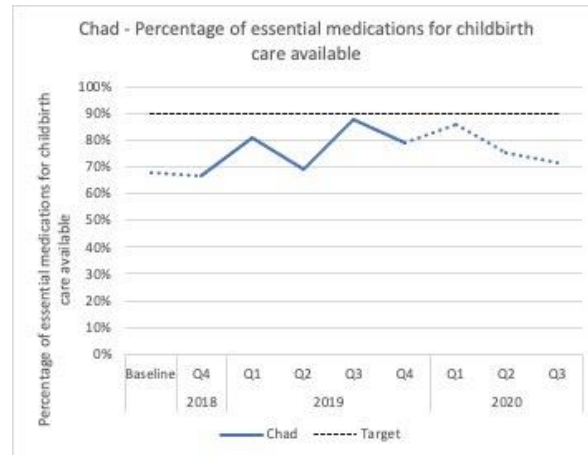
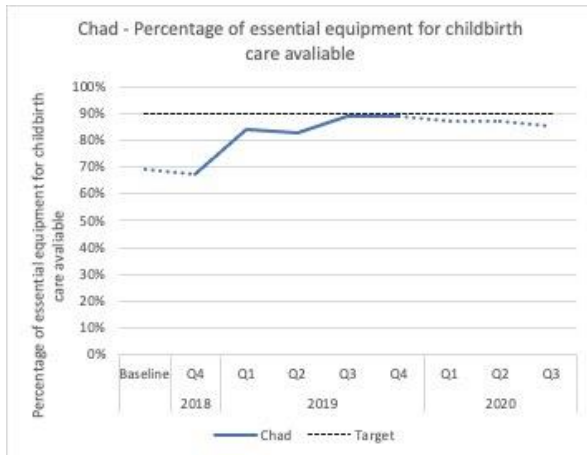
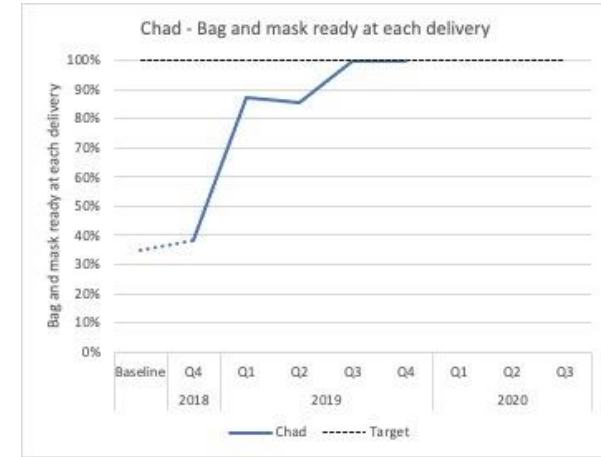
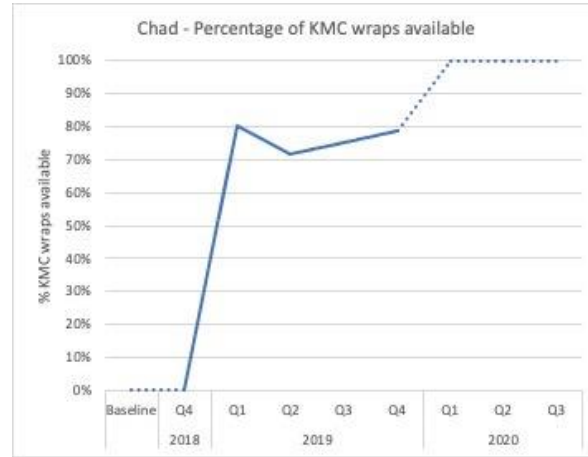
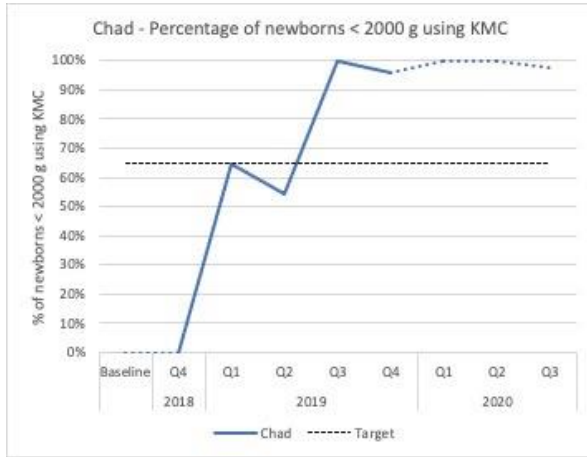
1.2	Adequate new-born supplies, equipment and guidelines/protocols to health clinics have been provided	% of health facilities with functioning newborn bag and mask available	35%	100%	38%	88%	86%	100%	100%	#DIV/0!	#DIV/0!	#DIV/0!
		% of HFs with KMC wraps available	0%	80%	0%	80%	71%	75%	79%	100%	100%	100%
2	Quality comprehensive maternal health services improved	Maternal mortality (crude numbers)	0	NA	4	1	6	0	3	5	7	0
		Stillbirth rate per camp/site (number of stillbirths per 1000 live and stillbirths)	18,5	14,8	31,3	19,3	33,6	27,2	26,2	30,1	26,7	29,0
		Average number of 7 signal BEmONC functions performed in the past 3 months	5,3	6,5	3,8	4,4	5,1	4,5	5,0	5,5	4,7	4,4
2.1	Capacity building of human resources: training of the health providers on routine and emergency obstetric care	Number and % of qualified health providers trained on routine and emergency obstetrics	8%	100%							Gore 98% Other 100%	
2.2	Adequate maternal supplies, equipment and guidelines/protocols provided to health clinics have been provided	% of essential equipment for childbirth care available in each health facility	69%	90%	67%	84%	83%	89%	89%	87%	87%	85%
		% of essential medications for childbirth care available in each health facility	68%	90%	67%	81%	69%	88%	79%	86%	75%	72%
		% of HFs have clinical protocols and guidelines available (*detailed reproductive health and HIV guidelines BSC-RH)	13%	100%	61%	99%	94%	88%	95%	94%	94%	94%
3	Quality comprehensive family planning services improved	<i>Contraceptive Prevalence Rate</i>	NA	NA	NA							
		Number of new users of modern contraceptive methods	1604	1925	1604	825	2071	1368	1778	2451	2809	2651

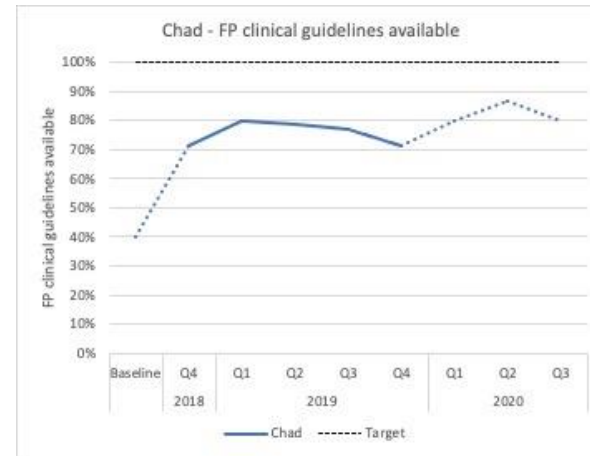
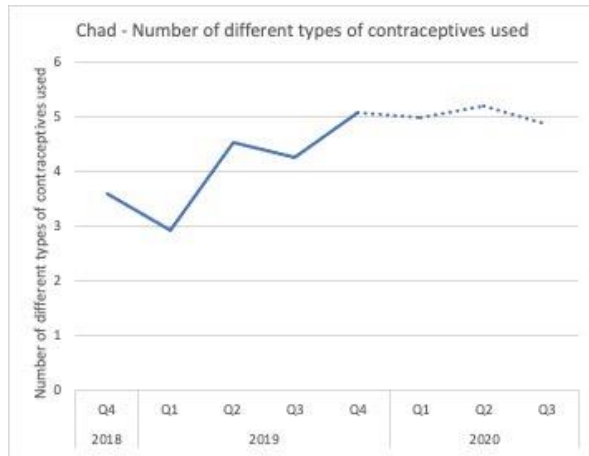
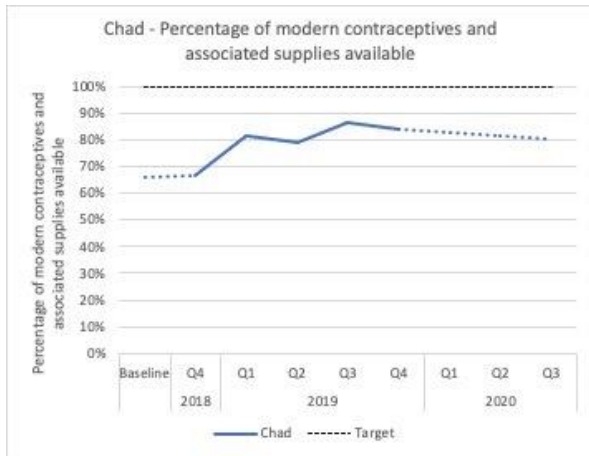
3.1	Capacity building of human resources: training of the health providers and community-based health workers on contraceptive counselling, contraceptive modern methods and sensitization and promotion strategies strengthen	Number and % of qualified health providers (doctors and midwives) trained on contraceptives methods and counselling	20%	100%								100%
3.2	Adequate contraceptive maternal supplies, equipment and guidelines/protocols provided to health clinics have been provided	Nb of modern contraceptives methods provided by health facility to clients over the last 3 months	NA		3,6	2,9	4,5	4,3	5,1	5,0	5,2	4,9
		% of modern contraceptives and associated supplies available at each health facility	62%	100%	67%	82%	79%	87%	84%	83%	82%	80%
		% of HFs have clinical protocols and guidelines in family planning available	40%	100%	71%	80%	79%	77%	71%	80%	87%	80%
4	Understanding of the specific situation of the new-born, maternal health care and family planning services and barriers has been achieved	Baseline assessment conducted	NA	NA	Done							

Outcome Indicators Chad – figures



Output Indicators Chad – figures



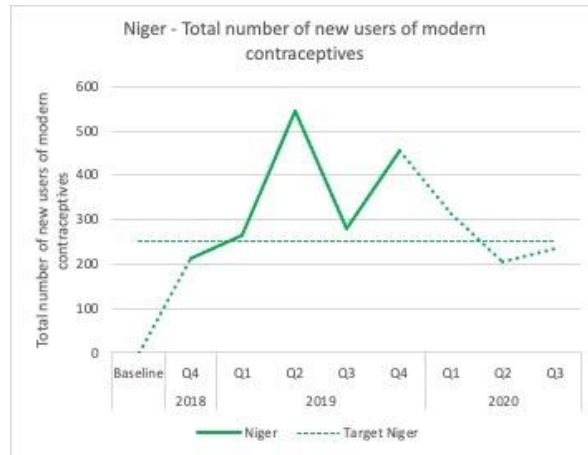
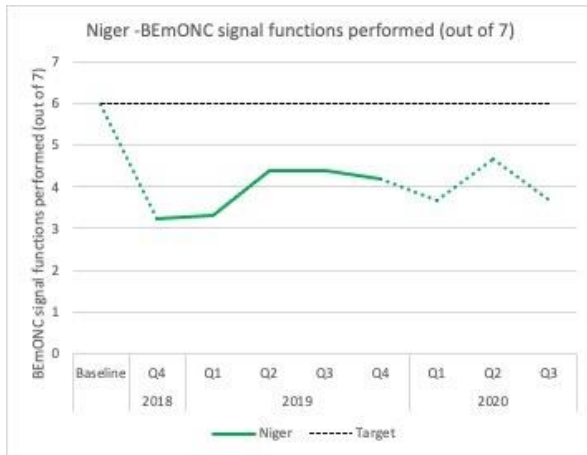
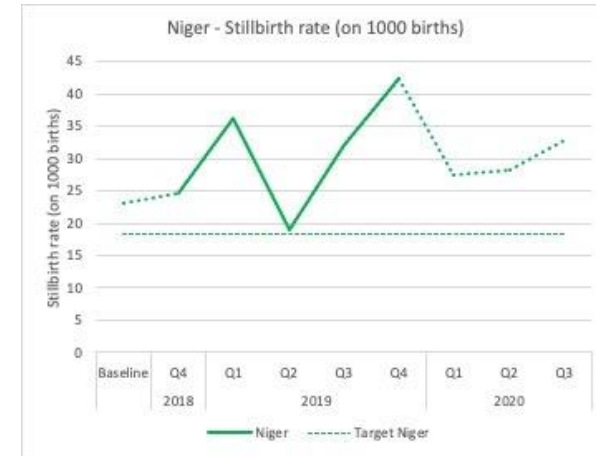
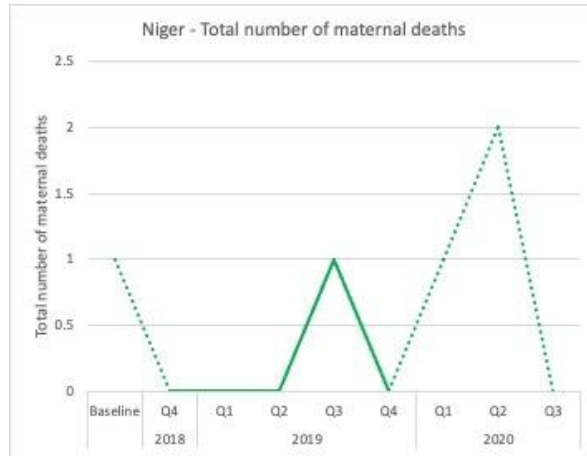
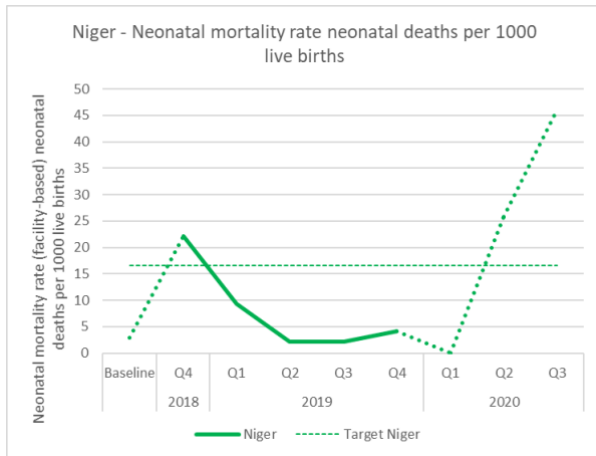


D. Summary Results Framework Indicators Niger

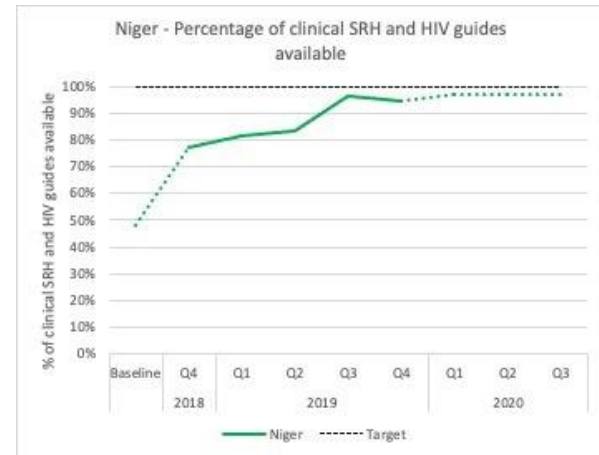
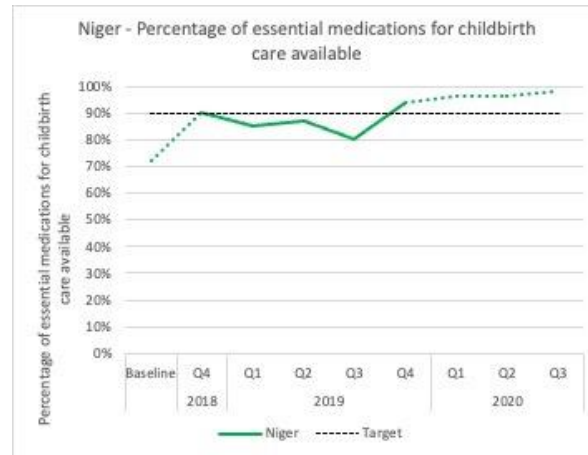
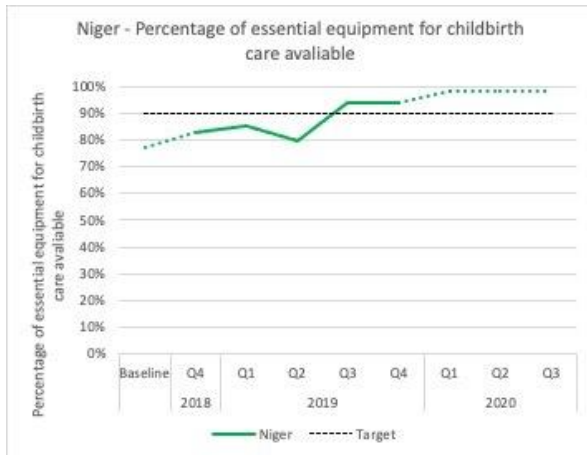
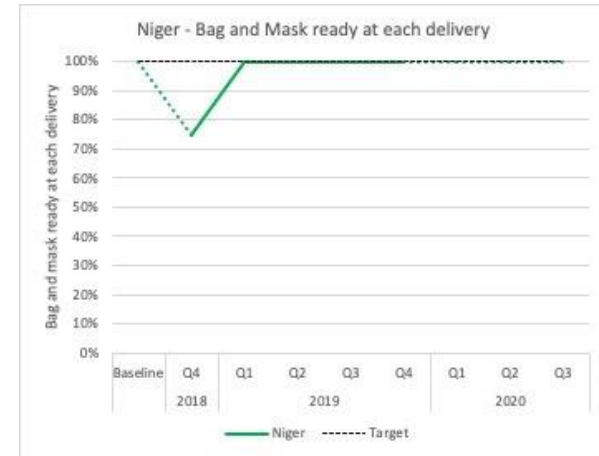
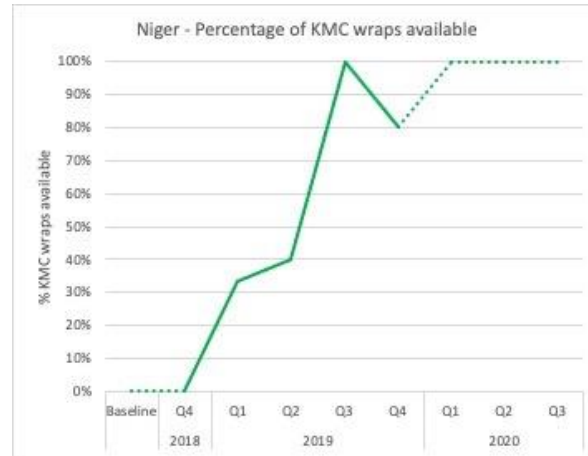
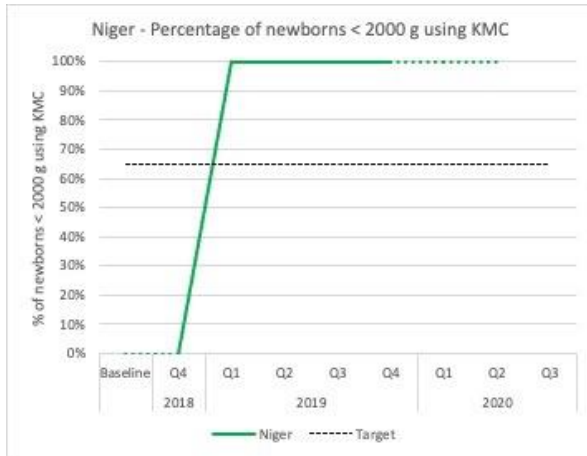
		Baseline	Target	Results								
				2018			2019			2020		
				Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	
Niger												
1	Quality, comprehensive essential newborn health care provided	NMR (number of neonatal deaths per 1000 live births)	2,9	(2,2)	22,2	9,4	2,1	2,1	4,2	0,0	25,8	46,2
1.1	Capacity of health providers and community-based health workers on essential new-born interventions strengthened	Number and % of health providers trained in essential newborn care	14%	100%					76%			
		Number and % of CHWs trained in essential newborn care	61%	100%					33%			
		% of health facilities providing KMC	43%	65%	0%				100%			
		% of babies < 2000 g placed in KMC	NA	65%	0%	100%	100%	100%	100%	100%	100%	NA
1.2	Adequate new-born supplies, equipment and guidelines/protocols to health clinics have been provided	% of health facilities with functioning newborn bag and mask available	100%	100%	75%	100%	100%	100%	100%	100%	100%	100%
		% of HFs with KMC wraps available	0%	80%	0%	33%	40%	100%	80%	100%	100%	100%
2	Quality comprehensive maternal health services improved	Maternal mortality (crude numbers)	1	NA	0	0	0	1	0	1	2	0
		Stillbirth rate per camp/site (number of stillbirths per 1000 live and stillbirths)	23	18,4	24,7	36,2	18,9	32,1	42,3	27,4	28,2	32,8
		Average number of 7 signal BEmONC functions performed in the past 3 months	6	6,5	3,3	3,3	4,4	4,4	4,2	3,7	4,7	3,7
2.1	Capacity building of human resources: training of the health providers on routine and emergency obstetric care	Number and % of qualified health providers trained on routine and emergency obstetrics	7%	100%						(100%)		
2.2	Adequate maternal supplies, equipment and guidelines/protocols provided to health clinics have been provided	% of essential equipment for childbirth care available in each health facility	77%	90%	83%	86%	80%	94%	94%	99%	99%	99%
		% of essential medications for childbirth care available in each health facility	72%	90%	90%	85%	87%	80%	94%	97%	97%	98%

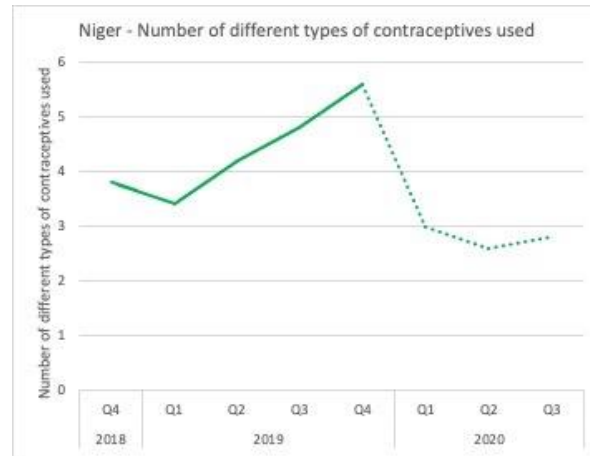
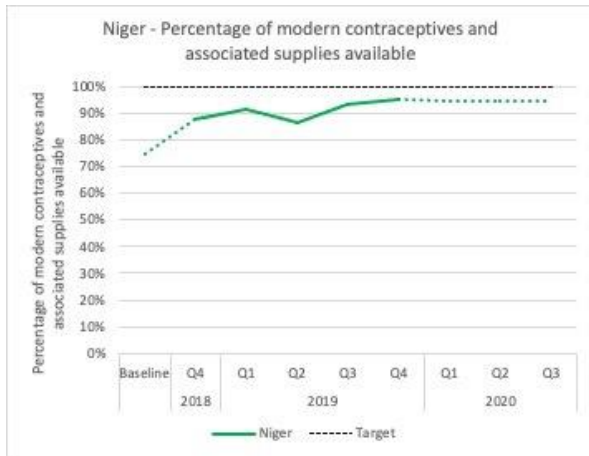
		% of HFs have clinical protocols and guidelines available (*detailed reproductive health and HIV guidelines BSC-RH)	48%	100%	77%	82%	84%	96%	95%	97%	97%	97%
3	Quality comprehensive family planning services improved	<i>Contraceptive Prevalence Rate</i>	NA	NA	NA							
		Number of new users of modern contraceptive methods	211	253	211	263	546	280	454	313	204	233
3.1	Capacity building of human resources: training of the health providers and community-based health workers on contraceptive counselling, contraceptive modern methods and sensitization and promotion strategies strengthen	Number and % of qualified health providers (doctors and midwives) trained on contraceptives methods and counselling	11%	100%					100%			
3.2	Adequate contraceptive maternal supplies, equipment and guidelines/protocols provided to health clinics have been provided	Nb of modern contraceptives methods provided by health facility to clients over the last 3 months	NA		3,8	3,4	4,2	4,8	5,6	3,0	2,6	2,8
		% of modern contraceptives and associated supplies available at each health facility	65%	100%	88%	92%	87%	93%	95%	94%	94%	94%
		% of HFs have clinical protocols and guidelines in family planning available	14%	100%	100%	100%	100%	100%	100%	100%	100%	100%
4	Understanding of the specific situation of the new-born, maternal health care and family planning services and barriers has been achieved	Baseline assessment conducted	NA	NA	Done							

Outcome Indicators Niger – Figures



Output Indicators Niger – Figures





E. Maternal Complications

Cameroon - Maternal complications										
	2018	2019				2020			Total	%
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3		
Postnatal haemorrhage	28	39	45	38	46	21	35	40	292	29,4%
Antepartum haemorrhage	8	24	4	10	2	7	6	3	64	6,4%
Obstructed or prolonged labour	88	48	54	35	36	48	41	46	396	39,9%
Uterine rupture	1	3	7	11	1	0	1	0	24	2,4%
Sepsis	1	1	2	1	4	1	1	2	13	1,3%
Severe pre-eclampsia or eclampsia	5	4	11	16	15	3	16	11	81	8,2%
Abortion complications (with haemorrhage or sepsis)	6	14	5	6	1	14	17	8	71	7,2%
Ectopic pregnancy	2	2	0	0	0	0	2	1	7	0,7%
Other	15	2	6	2	4	0	6	10	45	4,5%
Total complications	154	137	134	119	109	94	125	121	993	100,0%
Deliveries	1150	616	853	906	1001	831	949	926	7232	
Obstetric complication rate %	13%	22%	16%	13%	11%	11%	13%	13%	14%	

Chad - Maternal complications										
	2018	2019				2020			Total	
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3		
Postnatal haemorrhage	24	36	67	34	40	54	44	44	343	21,1%
Antepartum haemorrhage	10	18	28	5	57	30	22	20	190	11,7%
Obstructed or prolonged labour	77	26	86	49	103	105	84	96	626	38,5%
Uterine rupture	0	1	5	1	4	5	1	2	19	1,2%

Sepsis	1	6	1	3	5	1	5	11	33	2,0%
Severe pre-eclampsia or eclampsia	14	7	15	20	11	11	15	13	106	6,5%
Abortion complications (with haemorrhage or sepsis)	21	1	53	21	12	26	14	20	168	10,3%
Ectopic pregnancy	2	1	2	0	1	2	1	1	10	0,6%
Other	0	13	20	9	44	14	16	13	129	7,9%
Total complications	149	109	277	142	277	248	202	220	1624	100,0%
Deliveries	1817	1398	1835	1524	1971	2145	2046	1974	14710	
Obstetric complication rate %	8%	8%	15%	9%	14%	12%	10%	11%	11%	

Niger - Maternal complications										
	2018	2019				2020			Total	
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3		
Postnatal haemorrhage	1	1	7	2	6	7	10	8	42	14,1%
Antepartum haemorrhage	2	1	8	4	5	1	1	3	25	8,4%
Obstructed or prolonged labour	3	4	26	22	29	7	9	10	110	36,9%
Uterine rupture	0	0	0	1	0	0	0	0	1	0,3%
Sepsis	0	0	2	1	0	0	4	0	7	2,3%
Severe pre-eclampsia or eclampsia	3	2	14	12	14	14	21	8	88	29,5%
Abortion complications (with haemorrhage or sepsis)	5	0	8	0	2	2	0	0	17	5,7%
Ectopic pregnancy	0	0	0	0	0	0	0	0	0	0,0%
Other	3	0	0	0	0	1	1	3	8	2,7%
Total complications	17	8	65	42	56	32	46	32	298	100,0%
Deliveries	299	221	469	473	490	324	315	421	3012	
Obstetric complication rate %	6%	4%	14%	9%	11%	10%	15%	8%	10%	

Annex 8: Deliveries by Health Facility – Cameroon, Chad and Niger

Deliveries by health facility, Cameroon, Niger and Chad, 2018-2020

Number of deliveries Cameroon, Niger and Chad									
	2018	2019				2020			TOTAL
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	
Cameroon									
Lolo	93	98	90	99	72	75	83	88	698
Gado	168	156	176	137	126	133	227	126	1 249
Timangolo	29	30	37	40	22	24	42	55	279
Gbiti	58	37	42	29	33	39	34	52	324
Mbile	96	83	72	76	61	52	95	99	634
HD Gar-B	0	61	49	54	57	44	52	43	360
HD Kette	30	31	49	38	9	18	20	33	228
HD Batouri	44	16	40	21	20	10	13	18	182
Minawao	632	104	298	412	601	436	383	412	3 278
Total	1 150	616	853	906	1 001	831	949	926	7 232
Chad									
Dosseye	163	146	102	100	110	103	113	99	936
Doholo	73	69	75	86	78	35	43	62	521
Beureuh	108	168	176	157	160	148	159	126	1 202
HD Gore	209	NA	NA	157	185	138	162	155	1 006
Belom	205	230	220	216	259	205	206	244	1 785
Moyo	70	88	107	109	99	114	106	114	807
HD Haraze	NA	NA	88	NA	76	100	118	119	501
HD Maro	109	NA	120	NA	NA	91	92	94	506
Amnabak	123	132	188	187	109	165	163	153	1 220
Iridimi	138	135	168	131	115	168	157	165	1 177
Toloum	188	159	193	216	140	200	239	193	1 528
Kounougou	151	143	219	NA	284	178	170	132	1 277
Mile	100	128	109	NA	196	331	150	142	1 156
HD Iriba	108	NA	NA	116	95	103	121	120	663
HD Guere	72	NA	70	49	65	66	47	56	425
Total	1 817	1 398	1 835	1 524	1 971	2 145	2 046	1 974	14 710
Niger									
CSI Sayam	71	110	78	102	129	113	123	169	895
CSI Intekane	73	82	92	76	62	56	27	39	507
CSI Tabreybrey	43	29	22	39	22	NA	NA	NA	155
CSI Mangaize	112	NA	126	60	102	NA	NA	NA	400
CSI Abala	NA	NA	151	196	175	155	165	213	1 055
Total	299	221	469	473	490	324	315	421	3 012
Grand Total	3 266	2 235	3 157	2 903	3 462	3 300	3 310	3 321	24 954

Annex 9: Dissemination Activities

Target audience	<ul style="list-style-type: none"> * UNHCR public health, reproductive health and nutrition staff * Health and nutrition partner staff * Humanitarian actors
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Objectives	
Increase awareness and knowledge among UNHCR staff and partners on the importance of essential maternal and newborn care practices and family planning services and innovative strategies to better integrate them into UNHCR regular services	Dissemination and internal systematisation of essential newborn care
Activities	Activities
8 Webinars 2 x 1-page primers 6 Operational guides available on the web Monitoring tools available on the web 1 Stillbirth and neonatal mortality audit form Internal and external tools consolidation available on the web List of recommended online courses available on the web 2 Population based surveys, one in Chad and one in Cameroon 1 Partnership with Wash University Balanced score-card available in all UNHCR health programs Standard indicators integrated to IRHIS 100 facilities in 10 countries (2019); nearly 100 facilities in 8 countries (2020) CHW training manual available CHW's performance indicators available in 3 different languages already used in 7 countries Training package available through the UNHCR Community of Practice UNHCR nutrition road map Multi-sectoral framework for action (IYCF) available in all UNHCR health and Save the Children operations Kangaroo Care kit available in French Kangaroo wrap included into UNHCR Essential Drugs and Equipment List 5-page primer on KMC use available on the Web Samples of essentials clinical records available on the Web	Summary of the evaluation report available on the web Summary of the evaluation report with lessons learned and recommendations available on the web Presentations and discussions at regional workshop in Kenya UNHCR website UNHCR Global strategy for Public Health 2020 - 2025 to be done in the first half of 2021

Target audience	Specific UNHCR operations (such as Bangladesh)
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Objective	Activities
Support implementation of innovative approaches in maternal, newborn and family planning services in specific operations	Mission of the Saving Newborn Lives Project Manager to Cox's Bazar operation, done in Mission Chad, Cameroon and Niger Sharing and discuss Operational Guidelines, done in Mission Cox Bazar Sharing and discuss evaluation's findings and recommendations, done in mission Chad and Cameroon

Target audience	<ul style="list-style-type: none"> * National health authorities * Academics * Humanitarian and development actors * Donors
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Objective		
<ul style="list-style-type: none"> * Dissemination of benefits of essential low-cost high impact practices * Encourage evidence-based decision-making using project outcomes 	<ul style="list-style-type: none"> * Dissemination of appropriateness and benefits of the low dose, high frequency training approach and Master training strategy * Encourage evidence-based decision-making using project outcomes 	Dissemination of findings of the operational research on traditional and anthropological determinants on newborn health care in three refugee settings
Activities	Activities	Activities
<p>Baseline assessment findings, available</p> <p>Final evaluation project 1, available</p> <p>Final evaluation project 2, to be done in the second quarter of 2021</p> <p>Summary dissemination documents, available</p>	<p>Available training modules in English and French</p> <p>Available training materials in English and French</p> <p>Training reports ongoing</p>	<p>Publication and dissemination of articles, done</p> <p>Articles on baseline assessment published in peer review journals and shared widely, done</p> <p>Articles:</p> <p>Gee, S., Vargas, J. & Foster, A.M. "The more children you have, the more praise you get from the community": exploring the role of sociocultural context and perceptions of care on maternal and newborn health among Somali refugees in UNHCR supported camps in Kenya. <i>Confl Health</i> 13, 11 (2019). https://doi.org/10.1186/s13031-019-0195-z</p> <p>Article: Gee, Stephanie & Vargas, Josep & Foster, Angel. (2018). "We need good nutrition but we have no money to buy food": sociocultural context, care experiences, and newborn health in two UNHCR-supported camps in South Sudan. <i>BMC International Health and Human Rights</i>. 18. 10.1186/s12914-018-0181-3.</p> <p>Article: Gee, S., Vargas, J. & Foster, A.M. «I was scared to enter the hospital because I know the bad treatment for women giving birth»: A quality study of maternal and newborn health care practices among Syrian refugees in UNHCR-supported camps in Jordan", Pending for publication</p> <p>Article: Amsalu R, Schulte-Hillen C, Garcia DM, Lafferty N, Morris CN, Gee S, Akseer N, Scudder E, Sami S, Barasa SO, Had H, Maalim MF, Moluh S, Berkelhamer S. Lessons Learned From Helping Babies Survive in Humanitarian Settings. <i>Pediatrics</i>. 2020 Oct;146(Suppl 2):S208-S217. doi: 10.1542/peds.2020-016915L. PMID: 33004642.</p> <p>Article: Effect of Maternal Duration in Refugee Camps on Infant Birthweight (pending publication)</p>

Target audience	<ul style="list-style-type: none"> * Inter-Agency Working Group on Reproductive Health in Crisis (IAWG) members, * Academics, * UN agencies, * Humanitarian actors * Development actors
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Objective	Activities
* Dissemination of evidence-based innovative approaches in newborn, maternal and family planning provision of services	Project objectives and strategy, done Project progress reports, done Project evaluation findings and recommendations, done Abstracts, done Specific section in UNHCR Web Page, done Spotlight session on maternal and newborn health during the Global Refugee Forum, 1 in September 2019
* Mainstream the use of low cost, high impact newborn care practices	Newborn Health in Humanitarian settings filed manual, done Inter-Agency Field Manual on reproductive health in humanitarian settings, rescheduled for end of 2021
* Reinforce the dyad mother-newborn approach intervention	Development of Kangaroo Mother Care guidelines for district hospitals in Chad, completed together with National Mother and Child Hospital Presentation and interventions from the Gates supported project in East and West Africa at the Five-year Strategy Experts Meeting held in Geneva

Target audience	Ouagadougou partnership
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Objective	Activities
Collaborate on national and regional levels to address the high unmet need for family planning	<ul style="list-style-type: none"> * Project documents, in progress * Evaluation reports, pending information of dates of relevant meetings * UNHCR operational guidelines * UNHCR monitoring tools