



KIT | Health



Final report

Evaluation of a Postnatal Home Visiting Program for mothers, neonates and their families in Gaza, State of Palestine, over the period 2011 – 2016

commissioned by UNICEF State of Palestine under Contract no.
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Acronyms and abbreviations

ANC	Ante-natal care
APH	Ante Partum Haemorrhage
CHW	Community Health Worker
EBF	Exclusive Breast Feeding
ECD	Early Childhood Development
ECI	Early Childhood Intervention
ESC	Evaluation Steering Committee
FGD	Focus Group Discussion
GO	Government Organisation
GS	Gaza Strip
HMIS	Health Management Information System
IDI	In Depth Interview
IMR	Infant Mortality Rate
KII	Key Informant Interview
KIT	Royal Tropical Institute (Dutch Abbreviation)
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MoH	Ministry of Health
NA	Not Available
NECC	Near East Council of Churches
NGO	Non Governmental Organisation
NIS	New Israeli Shekel
OECD/DAC	Organization for Economic Cooperation and Development/Development Assistance Committee
PHC	Primary Health Care
PNC	Post-natal care
PNHV	Postnatal Home Visiting Program
PPH	Past Post-Partum Haemorrhage
PROM	Premature Rupture of Membranes
SRHR	Sexual and Reproductive Health and Rights
ToC	Theory of Change
ToR	Terms of Reference
UNICEF SoP	United Nations International Children's Fund State of Palestine
UNRWA	United Nations Relief and Works Agency for the Refugees of Palestine in the Near East
UHCW	Union of Health Work Committee
WB	West Bank
WHDD	Women Health and Development Department

Executive Summary

The United Nations International Children's Fund State of Palestine (UNICEF SoP) has contracted the KIT-Juzoor consortium to conduct **an external evaluation of the Post Natal Home Visiting (PNHV) programme for postnatal mothers, neonates and their families implemented in Gaza in a humanitarian context**. This **final report describes the purpose** of the evaluation, **the methodology** used, **its limitations** and **key evaluation finding and pointers towards recommendations** in relation to the PNHV programme in Gaza. The evaluation covers the period 2011 until the end of 2016.

Since 2011, UNICEF SoP supports a Postnatal Home Visiting Programme (PNHV) for most vulnerable mothers and new-borns after early discharge from the maternity ward in Gaza. The PNHV programme, as funded by UNICEF, started in 2011 with MoH as implementing partner and covers all five governorates of Gaza. Since 2014/2015 funding was also provided to the NGO Near East Council of Churches (NECC) to improve their already existing postnatal home-visit services around 3 PHC centres in Gaza City and Rafah. UHWC received funding from October 2015- December 2016 to conduct postnatal home visits for their target population in Gaza city and North Gaza. Currently, MoH and NECC are still conducting home visits, but funding by UNICEF is only granted till November 2018.

The **purpose of this external independent evaluation** is twofold: **firstly** it aims **to document and assess the relevance, efficiency, effectiveness, impact and sustainability of the PNHV programme**; and **secondly to identify good practices and areas for improvement to inform future programming and decision-making about strengthening post-natal care in Gaza** as well inform other initiatives that work towards reducing maternal and neonatal mortality.

The evaluation uses a mixed-methods approach involving a desk review and qualitative and quantitative data. The desk review involved reviewing and analysing reports and statistics about mother health, child health and postnatal care. Empirical in-depth data was collected through 36 in-depth interviews with women who have had high-risk pregnancies and male spouses, 15 key informant interviews with policy makers from MoH, UNWRA, UNICEF/UN staff and NGO staff; as well as focus group discussions with midwives and nurses. The analysis of existing large scale quantitative data focused on trends in health indicators. The results were triangulated which allowed for multi-layered rich analysis and reinforcement of the overall analysis.

As with any evaluation, this evaluation has a number of **limitations**, amongst others the **absence of baseline data and or a control site** and therewith a counterfactual and **lack of adequate documentation**. Nevertheless through conducting a literature review, re-analysis of secondary data from multiple sources, and data triangulation, the evaluation team was able to explore the effectiveness and impact of the programme.

Key findings

Relevance of the PNHV program

The 2010/11 **maternal and neonatal mortality rates in Gaza justified the introduction of the PNHV programme in 2011**. The overall MMR ratio in Gaza fluctuated between 28 and 29.4 per 100,000 live births in the period 2008 – 2011, and 11 new-borns out of 1000 live birth died within their first 28 days of life at the time¹. The relevance of post-natal care is further supported by different national

¹ Palestinian Central Bureau of Statistics. *Palestinian Multiple Indicator Cluster Survey 2010*. Ramallah, Palestine

documents such as the Health Sector Strategic Plan which recognizes the need to improve coverage as well as the quality of postnatal care in hospitals, homes and at PHC centres.²

Many key stakeholders interviewed, including those within the MoH, confirmed that it is **highly relevant to strengthen postnatal care within Gaza**, as there is wide recognition that neonatal mortality disproportionally contributes to infant and under five mortality. Also many stakeholders in Gaza acknowledged that in a setting where women leave the hospital shortly after delivery, a home visiting programme within the first 72 hours can contribute to the identification of complications.

Most women who had been part of the PNHV programme said that they had **experienced the visit as very useful**. They felt reassured through the visit that everything was fine with the baby, they felt appreciated, it avoided that they themselves had to travel to the clinic while not being physically able or not have money to pay for travel, or they felt to have received more personal attention than they would have received in the clinic. **Spouses and other family members were overall also supportive of the home visits, and believed it was of benefit to the women and neonates.**

The **midwives** said that the **PNHV programme** had **provided** them with the **opportunity to learn** more about what is happening in the communities and in families. This **improved contextual understanding helped them in building better relationships with their clients**. They also appreciated the additional training, and financial support (for travel). There was a wide variation in logistical needs of the midwives/nurses depending whether they worked for MoH, NECC or UWHC. MoH midwives often times have to arrange their own transport while transport was provided by NECC and UWHC. Many of the MoH midwives/nurses mentioned that home visits are not easy and come on top of their other work.

The **PNHV programme** in its design **addresses the strongly held believe in Gaza that postnatal care is only important for babies and not for women**. Within the PNHV attention is given to both, and therewith contributes to addressing this widely held notion. To enhance the chances for success involvement of fathers in the Palestinian context is essential. Although stakeholders think it is important to involve fathers, the current programme does not include systematic efforts to involve fathers of new-borns, and or address gender issues.

Efficiency of the PNHV programme

While **not sufficient (detailed financial) data** is available to **provide information about the cost-effectiveness of the PNHV programme**, we could calculate the costs per woman visited. These costs varied from US \$ 14 – 36,5 per woman included in the PNHV programme through either one, two or three visits. NECC and UWHC received thereby higher amounts per women visited than MOH. A cost-effectiveness analysis from a large cluster randomized controlled trial for new-born home visits in the first week of life by community based surveillance volunteers in Ghana showed that a 99% probability of such home visits being highly cost-effective.³

In terms of home visits conducted, **NECC and UWHC exceeded the number of women they planned to reach, while MOH exceeded in some years and underachieved in others.**

People in Gaza tend to ‘shop’ for services with different providers, because they know certain drugs will be out of stock in one place or they will get an extra ultrasound in the other place. This means

² MoH. Health Sector Strategic Plan: Gaza Governorates 2014 - 2018

³ Pitt, Catherine et al. "Cost and Cost-Effectiveness of New-born Home Visits: Findings from the Newhints Cluster-Randomised Controlled Trial in Rural Ghana." *The Lancet. Global Health* 4.1 (2016): e45–e56. PMC. Web. 11 Apr. 2018.

many pregnant women are registered at more than one place and receive double services, also in postnatal care. The lack of a centralized Health Information System makes it difficult to control this and coordination between the different providers about cases is absent.

While the distribution of doctors and nurses is reasonable in Gaza, specialty and subspecialty areas, including in midwifery and new-born care, are greatly under-represented. Out of the 40 nurses per 10.000, only 2 are midwives. **The PNHV programme used the available human resources within the system of MoH, NECC and UHWC;** no new nurses were recruited for implementation of the program. **The number of home visits to be conducted per nurse per day was perceived as too many.**

Postnatal care is not only insufficiently addressed in the health care system, but also in the training curricula of health providers. **Additional training was provided to the midwives and nurses for the home visits** to address this gap, but did not extent to a **broader pool of health providers working in MCH in order to integrate postnatal care more in their overall tasks and responsibilities.** The **PNHV programme** seems a standalone project with **limited integration in the continuum of MCH care;** from preconception and ANC at PHC level, to delivery at hospital level and back to PHC for postnatal and new-born care. PNHV for high-risk cases is said to fill the gaps of the health system, but the gaps are too large and cannot be tackled without addressing immediate postnatal care at hospital level and postnatal care at clinic level as well. The lack of coordination between the different levels of care is also reflected in the lack of communication, whereby the women herself after delivery has to inform her Primary Health Clinic or Provider directly after delivery in order to receive timely postnatal care at home. If the woman gets complications during labour and therefore becomes eligible for home visits she should inform PHC as well. If she is told to do so depends on counselling at the maternity facility.

Beside financial support, UNICEF's support consisted of capacity building of nurses and midwives and supervision during accompanying field visits, often followed by the monthly review and evaluation meetings, which according to stakeholder interviews resulted in improvements related to transportation or provision of mobile card with airtime. The technical assistance is perceived quite well, while the inconsistency of the financial support causes a lot of insecurity.

Despite the monthly review and evaluation meetings, the **program wasn't standardized between the three implementers and has room for quality improvements.** In particularly, the monitoring and evaluation system requires strengthening as it does not allow clear reporting on outcome indicators and or generating data for result-based planning or management.

Effectiveness of the PNHV programme

While health providers feel that their training is sufficient, other than around psychosocial disorders which is a speciality area that requires careful attention and specialized training, qualitative data from interviews, FGD's and observations reveal a **lot of variation in technical skills and commitment. Procedures are not followed consistently** and some basic health checks are skipped and there are differences between MoH, NECC and UHWC. This is also reflected in the time spent in the homes, varying from 10 minutes to several hours. There is **also scope for improvement in counselling techniques as health education is often centred around information giving, rather than real counselling focused on needs of the women.**

All providers and key-informant involved in the program were able to provide examples about cases that needed referral, such as late PPH, hypertension, sepsis (including as a result of a gauze left in the

vagina), new-born breathing problems and jaundice during the qualitative interviews. **Many believe that this has saved lives.** On the other side there are also examples of missed opportunities.

All stakeholders (women, husbands, home visitors and key informants) mentioned the **positive effect of the program on breastfeeding practices.** Women, especially prime-para, felt encouraged to breastfeed and recognized benefits of breastfeeding that they did not see before. Home visitors felt well equipped with knowledge and skills to make breastfeeding successful.

The home visits have made nurses and midwives more aware of many **traditional practices** still present within families. They as well as women interviewed said that the **PNHV programme was quite effective in changing these practices**, such as using oil and salt on the umbilicus, tight wrapping of the baby, and use of bitter substances for weaning off breastmilk.

In terms of uptake of **family planning, the results are more mixed.** While information is provided, the effect of the PNHV program on birth spacing and family planning is limited due to a range of socio economic political cultural dynamics, including the influence of husbands, mothers in law, notions about contraceptives affecting fertility, but also availability of contraceptive methods.

While many visited women felt psychologically supported by the home visit, some women interviewed said they were **not specifically assessed for or counselled on psychological problems** after delivery, while home visitors also said they needed further training on the provision of psychological support.

Counselling around **post physical exercises** goes in most cases not beyond the hand-out of brochures and advice to mobilize, while there is **no protocol about such postnatal physical exercises.** In addition, **a holistic approach towards Early Childhood Development was only recently introduced** in the training and the program, this has yet to be rolled out.

Men are not pro-actively involved by the home-visiting program. Whether they are participating during the home-visit and to what extent it is desired varies among women, husbands and health providers. They are often not encouraged to be present, but allowed if they show interest by themselves. Nurses noticed that the husbands care about the mother and the child issues; they shared the babies' care with their wives.

Between 2011 and 2014 only MoH conducted the home visit, within this time frame the number of women visited by the home program has increased from 2012 to 2013 but remained stable after that. Due to the joining of NECC and UHWC an increase in coverage is seen in 2015 and 2016. Also the coverage of the program as percentage of total live births went up: in 2012 **5.4 percent of live births received a home visit in Gaza Strip**; in 2013 this increased to 8.1 percent; in 2015 to 9.5 percent and in **2016 to 12.9 percent**⁴. According to the **MICS data a total of 45.3% (2010) to 55.3% (2014) of the women had any of the listed risk factors or were prime-gravida during their last pregnancy**, which does not yet include all risk factors (such as previous caesarean section or diabetes). This proportion is far higher than the current coverage of the home visiting program and without additional resources and more comprehensive strategies and approaches would be a huge challenge to reach.

When comparing women who delivered in the general population (MICS) to women in the PNHV program for age and education level in 2011 and 2014, **women who completed secondary school are relatively visited more often than women with minimal education.** Women under 25 are relatively visited more often, which probably has to do with many prime-para being visited. The **percentages of new-borns who do not receive a postnatal health check is quite low and lower in the south than in**

⁴ Note: the number of registered births does not take into account twin or multiple pregnancies and therefore the coverage of women having received a home visit might be underestimated.

the north. Women missing postnatal health checks varies strongly between governorates (from 14.4% to 48.5%). Social risks, e.g. economic status, distance to facility, literacy rate or (social) problems at home are currently not taken into account.

Qualitative data show that **women in rural areas risk to be left behind**. Visiting staff of the PNHV program is all female, which is logically explained by the fact that currently in Gaza people would find it culturally inappropriate if a male provider visits a young mother in her home. Some of these female midwives and nurses avoid to visit cases in border or rural areas because of fear for sexual harassment or dangerous animals, like dogs. Also transport is an issue and ambulances cannot easily reach houses in rural areas due to road conditions.

The **program data provide no characteristics of the new-born** to inform about the focus on **vulnerable children or children with disabilities**.

Sustainability

The PNHV programme works foremost with MoH midwives and nurses that were already part of the primary health care system, a system that is affected by the continuing humanitarian crisis within Gaza. **The programme in its design did thus build upon existing institutional and local capacities**. However, the capacity and commitment built towards home visits applies to the small pool of midwives and nurses involved in the programme only. **By being a standalone project the opportunity was missed to make postnatal care a more sustainable component of the continuum of care**. If the program stops now, home visits will stop and it is not considered likely that more women will return to clinics to receive postnatal care. For that postnatal care in the clinics should simultaneously be addressed and health providers in general should have strengthened capacities and be more aware of the importance of postnatal care.

While government stakeholders see the need for a postnatal home visiting programme, they also think that within the resource limited setting, exacerbated through the political instable and humanitarian crisis situation, **this is not feasible**. Postnatal care within a clinical setting has a higher level of ownership. MoH plans to focus on strengthening postnatal care within clinics to have wider coverage. UNFPA has plans to support postnatal care but more around creating demand for clinic based care. WHO is also working on supporting clinic based postnatal care.

NECC has plans to continue with postnatal home visits, like they have done for many years, but without donor support will not be able to implement the whole home visiting package. UHWC which does not receive any UNICEF funding currently, continued working on raising awareness around post-natal care, and incidentally undertake home visits for some critical cases.

The current budgeting system in Gaza is more a survival mechanism. In most recent years, funding for health from Ramallah has been substantially reduced. While postnatal care has been mentioned in the plans, there are no government resources set aside for this.

The Ministry of health has plans to enhance sustainability but has not yet developed any written plans on how to achieve this. There are also challenges in relation to the work of the reproductive health committee, the maternal mortality committee, and the neonatal mortality committee, in terms of having resources available to fund steps that need to be undertaken.

Within UNWRA, where the priority focus is also on strengthening postnatal clinical care, there are no sufficient financial or human resources to conduct home visits.

There are efforts though to analyse data, including postnatal care data, to put the issue more on the agenda. This is done by UNICEF and WHO together with the MoH.

Impact on mothers, health workers, families/ communities and others

Reanalysis of large scale existing databases complemented by qualitative data showed the following:

Most PNHV providers and key-informants belief there is an impact on the neonatal morbidity and mortality, which is also endorsed by international evidence. Home visits in the first week after birth are strongly recommended by the WHO to improve new-born outcomes, based on moderate quality evidence. **Secondary data analysis from MICS does not show an effect of the recent initiatives on neonatal mortality**, with a rate that seems to have stagnated between 2005-2009 (11.4 per 1,000 live births) and 2010-2014 (11.5 per 1,000 live births). **Secondary analysis show that maternal mortality has been going up and down with an overall decrease in mortality since 2011**. While there is an absence of quantitative evidence, qualitative evidence provides, as stated under the effectiveness section, many examples of cases that might have contributed to decreased maternal morbidity and mortality. These include detection of late PPH, hypertension and sepsis by the health providers during the home visits.

The impact on breastfeeding is believed by many to be the main success story of the program. Secondary quantitative analysis of **MICS data shows an increase in Exclusive Breast Feeding (EBF) in children under 6 months from 14.5 percent in 2000 to 36.4 percent in 2014**. While this increasing trend started before introduction of the program, it is remarkable that a steep increase can be seen between 2010 and 2014, after introduction of the program. **While it is difficult to prove attribution, it is possible that the program has been a trigger for this steep increase in EBF**. Not only because of high rates of EBF in the direct target population, but also due to spill-over effect of positive experiences to the community.

Contraceptive prevalence rate increased between 2000 and 2014 with a little over 40% of married women aged 15-49 years using any modern form of contraceptives. Unlike as with breastfeeding, **there cannot be seen a change in ongoing trend at the time of introduction of the program**. Furthermore, according to the 2010 and 2014 MICS, the **unmet need for contraceptives decreased from 17.0% to 10.7%, respectively**. The decline in unmet need between the 2010 and 2014 estimates is statistically significant for both birth spacing and birth limiting, meaning that in 2014 less women were not satisfied in their contraceptive need than in 2010.

Palestine, including Gaza, has been known for a high immunization coverage (90-100%) over many years. Therefore the PNHV program has no additional impact on immunization coverage.

Conclusions

In line with international evidence, this evaluation shows that **strengthening postnatal care in Gaza was highly relevant to accelerate the slowly decreasing maternal and neonatal mortality and morbidity at the time of the introduction of the PNHV programme**. While the PNHV programme serves a real need of high risk pregnancy/prime-para women, **there is room to move towards a more holistic approach to postnatal care. Without external funding the intervention cannot be maintained at the same level**.

While no **statistical evidence on the effects and impact of the programme can be provided, qualitative data point to a very high satisfaction rate by women visited; great appreciation of nurses and midwives to their training, who are also able to successfully address harmful traditional norms**

and practices. The **impressive effect on exclusive breastfeeding and midwives being recognized as strong agents of change towards exclusive breastfeeding is one of the biggest successes of the programme.**

While all stakeholders interviewed agree that strengthening postnatal care is very much needed, the **majority of stakeholders believe in strengthening of the clinical component** in order to be able to reach out to many more women in a resource constraint setting, and reduce the number of **visits to those who cannot come to the clinic.**

Lessons learned

There are many lessons learned during this evaluation, among key learnings are:

- In the first place, the home visits facilitated a more **personalized approach** and allowed looking into problems that women had with breastfeeding or harmful traditional practices. The personalized practical support was very much valued and said to have been **helpful for continued exclusive breastfeeding, counteracting harmful traditional practices but also for improving self-esteem of the women visited.** Building in personalized approaches into other reproductive health services, would seem to be worthwhile. This could also be further pursued through the **further development of the helpline** which is part of the PNHV programme but underdeveloped and not wide spread.
- An unintended consequence of the program that was not part of one of the objectives was that the **programme in many cases increased mutual understanding and respect between health providers and women.** Health providers mention that the home visits make them more kind and sensitive and increases their relation with people. This means that service providers who start to understand the reality of the persons they serve better, will also be able to enhance their relationship with their clients, an important lesson to enhance services through better relationship building.
- The home visits contributed to the **realization that women themselves also need post-natal care** and not only their infants. While some headway has been made in this thinking, this would need a much stronger focus and would warrant awareness raising activities.
- Conducting home visits after finishing primary tasks of nurses and midwives (MoH) is challenging; the NGO's start their home visits in the morning and divide the different tasks, including home visits, among the available nurses in the clinic. **When postnatal care is perceived as an equal component of the work, home visits can be done every moment of the day. Home visitors do not feel comfortable to conduct a visit alone and fear sexual harassment when they are out in the field.** In order to address these learning points, home visits to specific cases should be made part and parcel of routine jobs and also ensure safety procedures towards those conducting the visits.

Recommendations

- a. Following the gaps identified and lessons learned through this evaluation, the evaluation team created pointers for recommendation to strengthen postnatal care. These pointers were validated, further developed and prioritized by the Evaluation Steering Committee in Gaza during a participatory exercise in May 2018. The following recommendations are the outcome of that exercise: **UNICEF to work towards enhancing better integration of post natal care**

into Mother and Child Health services, whereby postnatal care for both mother and new-born are seen as an equal component of their MCH care. This should include acceptable appropriate quality PNC in the clinic and home visits where possible and needed. In line with the WHO recommendations this care may be complemented by additional mobile phone- or web-based contacts. In line with the National Health Strategy 2017-2022, UNICEF could work with the MoH and other stakeholders to create linkages with the Family Medicine approach.

- b. **UNICEF to work towards enhancing the quality of post natal care through amongst others**
 - a. **Working with MoH and other key players on the revision, standardization and implementation of the PNC protocols** and making these widely available and used in practice and training. Important thereby to address are amongst others: involvement of husbands; specific attention for those extra vulnerable and those socially at risk; maternal mental health, early child hood development, physical exercises and family planning.
 - b. **Working with other key stakeholders on the harmonization of services.** Integration of PNC in Family Health Care teams could be an important entry point for that and foster further contact between service providers and patients and reduce in the shopping of services.
 - c. **Supporting and lobbying (together with i.e. WHO) for a centralized Health Information System and improving programme documentation**
 - d. **Better coordination among providers** UNICEF and the MoH to identify and engage with partners that complement each other on the different components of the holistic PNC approach, including in hospitals, clinics and training curricula.
 - e. **Improving the capacity building structure around PNC**

EXCERPT 1 FROM A FOCUS GROUP DISCUSSION WITH HOME VISIT PROVIDERS IN GAZA NORTH

R: Honestly, it is very useful for people and society. Moreover, it helps to decrease the morbidity and mortality rates of children and mothers.

F: Do you have evidence that the home visits contribute to decrease the mortality rates?

R: Yes, there were many cases suffered from haemorrhage and severe anaemia (the haemoglobin blood concentration was seven or less) have been referred.

F: How did you approve that? Did you notice among the clinic's data that the number of deaths was higher before the postnatal home visits? Can you remember a story?

R: When you explored a case suffered from low haemoglobin blood concentration (seven) during the post-natal home visit and referred her to the hospital, where, they diagnosed it as a haemorrhage, it is considered a success story. Her family didn't know that danger signs, they thought that was normal because she was a prime gravida. We visit her at the right time, so we save her life. The same case according the babies especially bilirubin cases.

EXCERPT 2 FROM A FOCUS GROUP DISCUSSION WITH HOME VISIT PROVIDERS IN KHAN

"the people are satisfied from the home visit, they don't take any action or any step until we visit them. Then they ask us to be sure that the things they do are right or wrong. The home visit is very useful for both the mother and her baby. Its benefit is in the early detection of complications for both the child and the mother. Most ladies don't know about the postpartum hemorrhage but we discovered many cases who suffer from that. By referring them to hospital, we saved their life's. Once we discovered an infant with an imperforated anus. His mother didn't know about that. When I asked her during the visit if the baby defecated, her answer was no. When I tried to check the anal temperature, I found it (the anus) closed. This case is one of the thousand cases we had visited. This child if she had stayed undiscovered she may have died. Another case which was diagnosed by us is a baby with a heart problem. We referred him to the hospital where they diagnosed that he had a closure in the heart and they referred him to a hospital in Israel, we feel so happy when we early diagnose cases and refer them for treatment and save them from complications. People are so happy with our services".

1. Introduction

In order to provide the Ministry of Health (MoH), the United Nations International Children's Fund (UNICEF), United Nations Relief and Works Agency for Palestine (UNRWA) and other stakeholders with evidence on achievements, good practices and challenges about the Postnatal Home Visiting (PNHV) programme in Gaza, UNICEF State of Palestine (SoP) has contracted the KIT-Juzoor consortium to conduct an external evaluation of the PNHV programme focusing on mother, neonates, infants and their families covering the start of the programme until the end of 2016.

The evaluation was implemented in different phases, an inception phase consisting of a desk review, an inception visit of the KIT/Juzoor team to Gaza in November 2017 and ethical clearance of the protocol by the UNICEF Institutional Review Board (IRB) in February 2018. The data collection phase started in mid-February and continued until mid-March. Data processing and analysis took place alongside. While a formal data analysis workshop and data validation workshop were scheduled to take place towards the end of March, due to the political situation alternative arrangements had to be made, whereby the Juzoor team worked on the analysis in Gaza, and the KIT team in the Netherlands with regular consultation by Skype and email. During all the phases, close contact was maintained with UNICEF SoP, as well as with Evaluation Steering Committee members.

This final report describes the purpose of the evaluation, the methodology used and key findings around relevance, efficiency, effectiveness, sustainability and impact, as well as lessons learned and gaps identified in relation to the PNHV programme in Gaza to further inform UNICEF and its partners about possible future courses of action.

1.1 Context and description of the PNHV programme

This chapter contains a short description of the context and content of the programme.

Context

The Palestinian people have been exposed to a wide range of vulnerabilities since 1948, when several hundred thousand Palestinians were forcefully expelled from their original cities and villages and took refuge in the West Bank, the Gaza Strip, and surrounding Arab countries. Since then, the Palestinian Territories and diaspora have experienced numerous internal and external clashes with Israel.

In the past 24 years, the Gaza Strip has been 'partially autonomous', experiencing a partial transfer of authority from the Israelis to the Palestinian Authority. But Israel still has overall sovereignty, controlling borders, trade, movement of goods and people, the commercial market, water, the main sources of energy, the means of communications and security. This lack of control over its own affairs is compounded by the fact that for decades, Israel has followed a de-development policy in the territory, which has resulted in widespread poverty and economic collapse.

In 2007 Hamas gained control of Gaza and established its own *de facto* government structures, including ministries, courts and the police force. For the first time, the Occupied Palestinian Territories were politically divided by the emergence of two competing governments – one Fatah-backed government appointed by the Palestinian Authority (PA) President and controlling the West Bank, and one Hamas government controlling the Gaza Strip. Since 2007 till now, many initiatives to reconcile and unite the two entities were launched but unfortunately these efforts were in vain.

Since the start of the second Palestinian intifada in 2000, the Gaza Strip has suffered a process of increasing economic and political isolation, which culminated in the imposition of a land, air and sea blockade by Israel in 2006. This further intensified in 2007 in the immediate aftermath of Hamas' takeover of the Strip. The blockade comprises stringent restrictions on the movement of people, goods and services in and out of Gaza, including the complete closure of border crossings for a number of days. Despite the partial lifting of import bans in 2010, together with other measures aimed at relaxing restrictions, the blockade is still in force today, permeating every aspect of daily life for the entire population. The United Nations (UN) and other agencies have repeatedly called the blockade a 'protracted human dignity crisis' and a 'collective punishment', in clear violation of international humanitarian law (UN OCHA, 2009).⁵ In less than 5 years, Gaza has witnessed three wars (2009, 2012 and 2014) which resulted in more than 4000 deaths, tens of thousands of injuries and destruction of, among others, the health care system, such as clinics, hospitals and ambulances.

While considered by the United Nations Development Programme (UNDP) to be in the medium human development category, the Palestinian people remain highly vulnerable. The protracted occupation by Israel, which is punctuated by repeated conflicts and coupled with severe restrictions on the movement of both people and goods, has resulted in highly fragmented and distorted local economies which are overwhelmingly dependent on external aid (MOH, 2014)⁶. PCBS 2015 report indicates that 38% of the households in GS live below the poverty line and an additional 23% of the households live below the severe poverty line with women and children mostly affected.

⁵ Office for the Coordination of Humanitarian Affairs (2009) Field update on Gaza from the Humanitarian Coordinator. Gaza

⁶ Ministry of Health (2014) Health Sector Strategy Plan: Gaza Governorates 2014-2018. Gaza: Ministry of Health

The Gaza Strip (GS) is a narrow sliver of land between Israel and Egypt, home to around 2 million people packed into one of the world's most densely populated areas with around 5500 inhabitants per square kilometre. The Strip is divided into five governorates. Running south to north, these are Rafah, Khan Yunis, Deir al-Balah, Gaza City and the North Gaza governorate. The majority of Gazans are refugees (66%), most of whom were forcibly displaced in 1948 from nearby areas. The average family has 6.3 persons and nearly 50% of the population are aged 0-15; 23.9% are women at reproductive age (UNFPA, 2016)⁷.

Figure 1 Governorates of Gaza



In Gaza, reproductive health services are an integral component of the health services. The four major providers are the MoH, UNRWA, NGOs, and private for-profit operators. The MoH is responsible for a significant portion of primary, secondary, and some tertiary health care (providing more than 50% of services) (MoH, 2014). It runs 56 PHC centres (at 28 of them MCH services are provided and at 15 of them family planning services are provided) and 13 hospitals (at 5 of them maternity services are provided). The ministry buys tertiary services from other providers, locally and abroad (MoH, 2014).⁸ UNRWA plays an important role in the sector, delivering free PHC services through 22 centres and buying secondary and tertiary services for registered Palestinian refugees (UNRWA, 2016). It also contracts NGOs to provide certain services, mainly specialties in secondary and tertiary care including deliveries (MoH, 2014). The NGO sector also plays a vital role, complementing the work of the MoH in providing (often costly) tertiary services that the Ministry is unable to provide especially rehabilitation services. NGOs do a great deal of work to make health care accessible to vulnerable and marginalised groups, running more than 50 centres providing health and health-related services. They also contribute to bridging the gaps and perceived inequalities in the health system. In particular, NGOs are an important provider of psychosocial and mental health and rehabilitative services in Gaza⁹(Yaghi, 2009). The private sector is largely unregulated, and tends to focus on obstetrics and surgical intervention (MoH, 2014).

Annually, in Gaza there are between 50,000 to 60,000 deliveries with around 160 deliveries per day. Nearly all deliveries are institutionalized and attended by skilful birth attendants. 25% of women delivered with assistance by a midwife/nurses and the rest were assisted by a physician.¹⁰

⁷ United Nations Population Fund UNFPA (2016) Palestine 2030. Demographic Change: Opportunities for Development. Palestine: UNFPA and Prime Minister's Office (<http://palestine.unfpa.org/publications/palestine-2030-demographic-change-opportunities-development>).

⁸. see footnote 2

⁹ Yaghi, A. (2009) 'The role of NGOs in supporting the Palestinian health sector'. Master's thesis, Al-Quds University.

¹⁰ Palestinian Central Bureau of Statistics, 2015. Palestinian Multiple Indicator Cluster Survey 2014, Final Report, Ramallah, Palestine

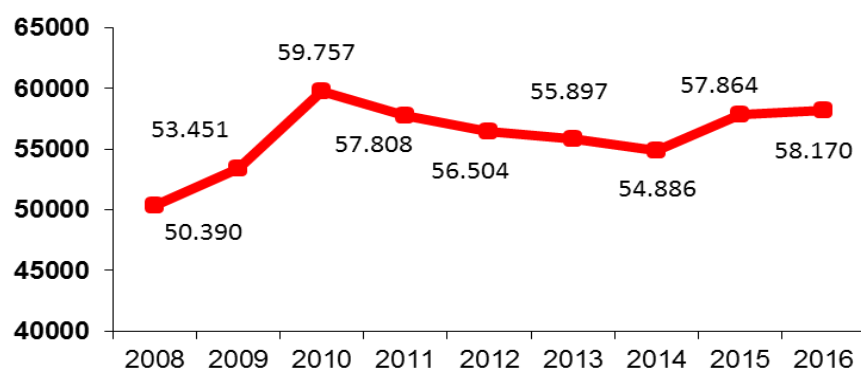


Figure 2 Number of deliveries in Gaza

The vast majority of pregnant women receive more than the 4 WHO recommended ANC visits (mean 6.8 in Gaza). MoH statistics, indicate that around 26% of pregnancies registered at MOH clinics are high risk ones (MOH, 2016).

Despite huge improvements in the past 15 years maternal (MMR) and neonatal mortality rates (NMR), are still high and have not achieved the Millennium Development Goal (MDG) targets (see also relevance chapter). In 2008, the countdown to the 2015 initiative called for strengthening of Post Natal Care (PNC) services and better data availability and quality on this topic. Therefore the Palestinian Multiple Indicator Cluster Survey (MICS) of 2014 reported for the first time on Post Natal Health Checks. It showed that more than half of the women in Gaza remain less than six hours in a facility after delivery. Also, more than half of the women have the first health check for their new-

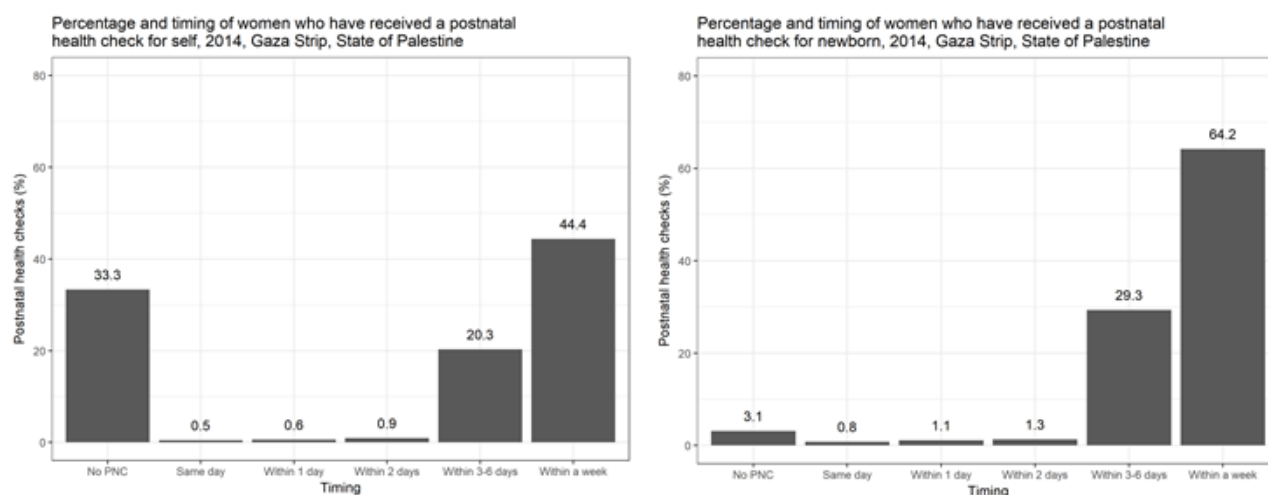


Figure 3 postnatal care for mother and new-born

born only one week after delivery and even less women have a health check for themselves. A third of the women do not receive any postnatal care¹¹.

The level of PNC remains at an unacceptable level in terms of coverage, quality of services and the frequency of visits despite of the progress made over the last 10 years. Post-natal visits are infrequent in number and mainly linked to the BCG vaccine given to the newly born-usually only one visit is

¹¹ Palestinian Central Bureau of Statistics. *Palestinian Multiple Indicator Cluster Survey 2014*. Ramallah, Palestine; 2015. <http://www.pcbs.gov.ps/Downloads/book2175.pdf>

utilized, in case it is conducted. The Post Natal Home Visiting (PNHV) programme aims to fill the gaps in postnatal care and therewith improve maternal and child health.

The Post Natal Home Visiting programme

Since 2011, UNICEF SoP supports two programmes in order to improve perinatal, neonatal and postnatal services in the SoP and reduce maternal and neonatal mortality, morbidity and developmental complications. This being a Postnatal Home Visiting Programme (PNHV) for most vulnerable mothers and new-borns after early discharge from the maternity ward in Gaza; and a programme to improve the Neonate Health Care (NHC) services at facility level, with special focus on secondary care at hospitals in Gaza and West Bank. This evaluation focusses primarily on the PNHV programme.

The PNHV programme, as funded by UNICEF, started in 2011 with MoH as implementing partner and covers all five governorates of Gaza. Since 2014/2015 funding was also provided to NECC to improve their already existing postnatal home-visit services around 3 PHC centres in Gaza City and Rafah which visits all women irrespective of having had a risk pregnancy or not. UHWC received funding from October 2015- December 2016 to conduct postnatal home visits for their target population in Gaza city and North Gaza. Currently MoH and NECC are still conducting home visits, but funding by UNICEF is only granted till November 2018. This evaluation, covering the activities from 2011 until the end of 2016, should inform future plans for the PNHV programme.

The main objective of the PNHV program is to reduce maternal and neonatal mortality and morbidity, by ensuring the continuum of care after the discharge of high-risk mothers and new-born from the maternity ward. This is done through:

- i. training of midwives and nurses on postnatal care skills and home-based child health; from MoH a group of 30 midwives and nurses is trained on postnatal care skills and home-based child health care.
- ii. provision of postnatal home visit kits which include equipment, devices and consumables needed for providing PNC by midwives and nurses conducting the field visits.
- iii. conducting home visits targeting high risk women and their new-born within 48-72 hours after delivery, followed by a second visit after one week and a third visit at the end of the puerperal period, 42 days after delivery¹². This number and timing of postnatal contacts is in line with WHO recommendations on postnatal care (2013)¹³. However, because of practicality constraints (staff, transport) from 2013 the second and third visit within the MoH program are only conducted at home if required by the health condition of the mother or the baby.¹⁴

The objectives of the home visits are as follows¹⁵:

1. To detect any health problems among mothers & babies.

¹² MoH work plans 2011 & 2012

¹³ WHO (2013) recommendations on postnatal care of the mother and new-born. Recommendation 1 and 2: care in health facility for at least 24 hours after birth; if birth is at home first postnatal contact as early as possible within 24 hours of birth; at least three additional postnatal contacts, on day 3 (48-72 hours), between days 7-14 and 6 weeks after birth.

http://www.who.int/maternal_child_adolescent/documents/postnatal-care-recommendations/en/

¹⁴ MoH workplans 2013, 2014, 2015 & 2016

¹⁵ MOH workplans 2011-2016

2. To promote better care of new-born with special emphasis on nutrition and cleanliness.
3. To promote breastfeeding practices mainly the exclusive breast feeding and assist the mother for good attachment.
4. To provide preventive care to avoid any complications after delivery such as bleeding and inflammation of breasts and infected wound.
5. To provide psychological support for the women in order to reduce postnatal psychiatric disorders, such as depression and psychosis.
6. To encourage mother to have postnatal check-up and undertake follow-up visits to health centres.
7. To encourage mothers to do postnatal complex of physical exercises.
8. To increase awareness of mothers about the importance & benefit of spacing between pregnancies and counsel on family planning.
9. Promote immunization.

Since 2015 there have been efforts to integrate Early Childhood Development and early detection of children with developmental delays and disabilities and Interventions in the PNHV program.¹⁶

At every home visit a checklist is filled in. Some information on the health status of mother and new-born is introduced in the data system once being back in the facility, but not added to the patient file of the mother. NECC uses android tablets instead of paper checklists. All agencies have different Health Management Information Systems (HMIS) which are not connected to each other or to a central database. MOH, with the support of WHO, only started this year with an online HMIS.

After the last home visit, the woman visited is requested to fill in a questionnaire about her perception and satisfaction of the PNHV. The outcomes of these questionnaire are used in the statistical reports and the monthly review and evaluation meetings.

Budget of the initiative

The budget plans for 2011-2016 indicated total budgets for the programme as presented in table 1. As programme periods did not necessarily run from January to December, the years are indicative. Information is abstracted from documents as provided by UNICEF (work plans and program progress reports). A full financial overview of the program, including total expenses for UNICEF to run the program, has not been made available.

Year	MoH	NECC	UHCW
2011	155.050,00 NIS (New Israeli Shekel)		
2012	244.373,20 NIS		
2013	230.290,00 NIS		
2014	217.524,00 NIS		
2015	315.660,00 NIS	222.863,16 NIS ¹⁷	
2016	281.260,00 NIS	752.888,94 NIS ¹⁸	589,621 NIS ¹⁹
Total	1.444.157,20 NIS	975.752,10 NIS	589,621 NIS

Table 1 Budget for the PNHV programme for each provider per year

¹⁶ MOH workplans 2015-2016; UHCW program progress report

¹⁷ Program progress report NECC Part 2; Reporting period from 17/2/2015 to 16/2/2016

¹⁸ Program progress report NECC Part 2; Reporting period from 10/4/2016 to 31/10/2016, includes management of malnutrition programme

¹⁹ Program progress report UHCW; Reporting period from 10/2015 to 12/2016

In general these budgets consist of:

- Secretary for central and districts
- Stationary and duplication
- Hospitality for monthly review & evaluation meeting
- Transportation for home visits
- Statistician and data entry
- Printing of the forms
- Mobile cards for communication
- Training activities
- Medical PNHV kits (one-off investments)
- IT equipment (one-off investments)

In case of NECC and UHWC, also staff such as midwives and doctors, drugs and medical supplies are included. In addition, the NECC budgets include the management of a malnutrition program and UHWC budget includes clinic counselling and awareness sessions. Currently UHWC dropped out of the programme due to less funding becoming available, while NECC is now also the funding channel for the MoH. However, it is not clear whether the 2016 budget of NECC as shown in Table 1 is for NECC only or includes part of the MOH budget.

Beneficiaries

The primary beneficiaries are mothers with their new-borns and families. Due to insufficient funding to cover all mothers and new-borns in Gaza, it was decided to focus on the high-risk cases and prime-para women.

There are clear criteria for high risk pregnancy. These risk factors are assessed during pregnancy and guided by the MCH-book that every woman should possess. A risk assessment is done for²⁰:

<p>A. Risks related to Medical & Obstetrical History (on booking):</p> <ul style="list-style-type: none">- Age <16 or >40 years- Consecutive abortion (≥3)- Peri-natal deaths (≥2)- Previous Caesarean Section- Other Uterine Surgery- Grand Multiparity (≥6 deliveries)- Past Ante-Partum Haemorrhage (APH)- Past Post-Partum Haemorrhage (PPH)- Pre-existent Diabetes- Pre-existent Hypertension- Heart/Renal Disease- others	<p>B. Risks related to current pregnancy:</p> <ul style="list-style-type: none">- Gestational Age- Gestational Diabetes- Signs of Pre-Eclampsia- Vaginal Bleeding- Anemia (Hb <9.5 g/dl)- Discrepancy of Fundal Height- Oligo/Polyhydramnios- Malpresentation at ≥ 36 week- Absence of Fetal Movements > 24 weeks- Multiple Pregnancy- Premature Rupture Of Membranes (PROM)- Rhesus incompatibility- Pelvic mass- others
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Table 2 Risk Assessment according to MCH handbook

In addition a woman can become high risk during delivery, such as delivery through caesarean section or post-partum haemorrhage. The program selection criteria for delivery associated risks are not documented as such. According to MoH estimations about 26% of the pregnancies in Gaza are high

²⁰ Mother and Child Health Handbook (UNICEF; UNRWA)

risk, with around 55.000 deliveries per year this means about 14.300 high risk cases plus a number of prime gravida's. The PNHV program is able to cover around 5000 cases per year (see also chapter on efficiency).

Besides the medical risk assessment no criteria are developed for inclusion based on social or psychological risk assessment, e.g. economic status, distance to facility, literacy rate or (social) problems at home. Women throughout Gaza are eligible for the program, without exceptions in geographical location.

Another group of beneficiaries are the nurses and midwives whose skills were strengthened on postnatal care and home visiting. Midwives and nurses in all governorates of Gaza were selected and trained to implement the PNHV programme.

Stakeholders

The ToR specified that the evaluation should reflect the voices and views of all stakeholders. The evaluation design therefore places special emphasis on **mothers with infants and their families, especially those in the most deprived areas in Gaza**, by involving mothers and fathers in interviews and focus group discussions. The women covered by the PNHV programme (Gaza) are women who had high-risk pregnancies and the programme includes focus on their families.

Other stakeholders that were covered by the evaluation are **midwives and nurses who conduct post-natal home visits, other health care professionals, programme managers, UN-representatives and policy makers**. In addition, **all key stakeholders involved in post-natal care in Gaza, have also included in the evaluation steering committee** to obtain their guidance. During the inception phase, the evaluation team supported the establishment of steering committee for this evaluation which included representatives of the key stakeholders and also has developed clear terms of reference for the steering committee (Annex 4). The steering committee consists of staff from UNICEF, in their capacity of having the overall coordination and being the funder of the programme; staff from the Ministry of Health in their capacity of being responsible for the programme and its implementation from the Ministry of Health side; staff from NECC and UHWC in their capacity of (ex)implementers of the programme; staff from UNRWA as they are responsible for post-natal care for the refugee population in Gaza with funding from elsewhere; and staff from WHO and UNFPA as these UN agencies are both working on post-natal care in Gaza as well.

The evaluation steering committee reviewed and endorsed the detailed methodology of this evaluation and also provided significant input to the development of the Theory of Change. Finally, it is also foreseen that the steering committee will endorse the findings and support the uptake of recommendations at programmatic and policy making levels.

Financial resources for the evaluation have been made available by UNICEF State of Palestine.

Addressing human rights, gender and equity by the programme

Human Rights are a core component in many aspects of maternal and new-born health. Women and their children not only have the right to survive from pregnancy and childbirth, but also they have the right to decide on when to get pregnant, how to deliver and the right to access quality and respectful care, including the right to information, the right to shared decision making and informed consent, the right to have a birth companion and many more. Although not explicitly written down in project proposals these rights are the fundamental vision the PNHV programme is built on.

The postnatal period is a critical phase in the lives of mothers and their babies and has unrightfully received little attention in the past. This programme aims to increase access to postnatal care, achieve better health for mothers and their babies and create awareness about related health issues, including the opportunities for family planning, by visiting mothers and babies in their homes. Efforts to improve overall postnatal care, starting directly after delivery in the maternity, continuing in the postnatal ward and neonatal unit and thereafter in the postnatal care services at the PHC facilities are also made in Gaza, but are not integrated in the scope of this home visiting programme.

Because capacity lacks to conduct postnatal home visits to all women who deliver in Gaza, priorities have been set to reach the most vulnerable through the MoH supported component (while NECC visited all postnatal women). These, being the medically high-risk cases, are the ones most at risk to have postnatal complications and suffer from morbidity and mortality. No criteria are developed to reach those who are socially most at risk, e.g. early marriages or home-based violence, and/or those who are most likely to face access problems for (postnatal) care, e.g. because of low economic status, low literacy rate, distance to facility, or (social) problems at home within the MoH postnatal home visiting programme. Also consanguinity is not a criteria for selection for the PNHV programme.

All geographic zones in Gaza (North Zone, Gaza City, Deir al-Balah or midzone, Khan Younis and Rafah) are addressed by the programme. As the work of the NGO's focusses especially on poor and marginalized people, these groups were specifically included by expanding the program through the work of these NGO's. Whether the geographic areas and different educational groups were equally addressed and therefore contribution to equity was made, has been looked at in both the data collection as well as data analysis phase of the evaluation as can be seen in the findings section.

Male involvement is an essential component in Sexual and Reproductive Health and Rights (SRHR) and associated with improved maternal health outcomes. While the postnatal home visits focus on 'mothers and their families' specific strategies to engage fathers are not described. Instead, during the interviews often reference was made to 'fathers involvement is not part of our culture' and the fact that men are not allowed access in many ANC and maternity services.

The evaluators have made specific efforts to address human rights, gender and equity the evaluation as cross cutting issues. Attention for these issues is reflected in the Theory of Change, the data collection through the data collection instruments, but also in the analysis and reporting. In addition, respondents in all interviews and FGDs, data analysis and reporting, were disaggregated by sex.

1.2 Conceptual framework: Theory of change of the PNHV programme

The evaluation team has reconstructed the Theory of Change (ToC), and the underlying assumptions influencing the delivery of the desired outcomes, for the PNHV program, as such a ToC did not exist. A TOC is *"a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context"*. In a ToC the underlying beliefs, assumptions, conditions, interventions and strategies which are critical for the desired change to come about and the links between those, are made explicit.²¹ As a result ToCs are helpful to analyse programmes and policies that have multiple strategies and activities at different levels, with different variables and

²¹ Center for Theory of Change <http://www.theoryofchange.org/what-is-theory-of-change/> CHD program documents and the GAC Results chain

assumptions, taking into account the contexts in which programmes are implemented. They facilitate analysis around how and why change has (not) happened.

The reconstruction of the PNHV programme's ToC was done on the basis of document review, a range of stakeholder interviews, and postnatal home visit observations identifying the underlying conditions and beliefs that feed into the programme. The resulting ToC is focused on the PNHV programme as it was originally intended, has been rolled out but also to identify possible gaps within the PNHV program. During the inception workshop with various stakeholders the draft ToC was shared with stakeholders from the Ministry of Health, NGOs, UNRWA, WHO, UNFPA, and UNICEF. The stakeholders were subsequently asked to – in smaller parallel groups – critically review the draft ToC and matching assumptions, see what they liked, wanted to improve, and or add. The outcome of the group work was subsequently shared and discussed. The idea was to reconstruct the ToC in line with how the program was intended to be, how it was implemented over the course of 2011 – 2016 and to point out possible gaps in order to achieve the desired ultimate outcomes. The further informed and by the participants validated ToC and assumptions have been presented below. Thereby it has to be realized that the ToC provides a more detailed description of the PNHV programme as compared to the description provided in section 2.2, as the ToC includes additional insights obtained through the interviews and the validation exercise that are not reflected in programme documents.

The TOC has been used to :

- 1) Fine-tune the questions and sub-questions in the evaluation framework for the data collection in Gaza;
- 2) Review and adjust the evaluation design and data collection methods and analysis;
- 3) As an additional framework to analyse the findings from the qualitative data collection and secondary data, including in relation to outputs and outcomes achieved against resources used and activities implemented

The reconstructed TOC is visualized in paragraph 1.2.2 and the narrative provided below.

Description of the ToC visual

The ToC sees as ultimate outcome (impact) of the PNHV programme that Gaza mothers, including adolescents, and their infants have improved health outcomes, and reach their full potential in health and well-being. This can be realized if the combined intermediate outcomes, that of behaviour change among mothers, fathers and extended families, along the whole spectrum of the PNHV package; in combination with increased access to a quality comprehensive health system; along a strengthened continuum of care around Maternal and Child Health, can be realized.

The intermediate outcomes can only be achieved if the immediate outcomes are realized, which in turn depend on whether the outputs are realized as result of the different strategies that are envisioned. There are different strategies targeting different actors. These actors are infants and mothers; fathers and extended families; health providers; and the health system. For each group of actors, specific strategies are or should be in place in order to be able to realize the necessary outputs, immediate outcomes, and intermediate outcomes to be able to achieve the ultimate outcome.

- a) conducting home visits targeting women and their new-borns (identified as high risk and/or prime gravida) just after delivery, followed by a second and third visit if required by the health condition of the mother or the baby. Outputs of this strategy include infants and mothers receiving three post-natal

contacts with as result early identification of problems and referral where needed; the creation of optimal conditions for breastfeeding and early child hood development, and counselling along the whole postnatal care spectrum. All this is meant to increase detection and timely referral and increased knowledge and awareness, which in turn is meant to translate into behaviour change and increased access to post-natal care and ultimately improved health outcomes.

- b) postnatal care in facilities for those who are not eligible for the home visiting program; and through informing women during antenatal care about post-natal care services, including home visits and instructions to inform their health clinic following delivery. This strategy is used to prioritize the women under strategy a, and the programme itself does not have specific outputs, and outcomes linked to this strategy, as it does not focus on this group;
- c) No specific strategies have been formulated at the onset and during the course of the program to engage fathers and extended families, although according to some stakeholders this is something that has been described in concept papers related to the program. However, without a specific strategy for these actors, support for the necessary behaviour change within the homes of the post-partum mothers will be challenging. This strategy would be an important one to be able to achieve the desired support from spouses;
- d) Training and equipping midwives and nurses on postnatal care skills and home-based child health care; providing them with home visit kits; and supervision and mentoring. This strategy leads to trained and equipped midwives and nurses, who have the skills and are able to provide post-natal care, including home visits, and as such contribute to an improved quality comprehensive health system and therewith improved health outcomes.
- e) The last strategy that is essential for achieving the desired intermediate outcomes is that of building national capacity to monitor, keep track, integrate attention and the means for postnatal care in the system, leading to a strengthened continuum of care around maternal and child health, which in turn feeds into improved health outcomes for mothers and children

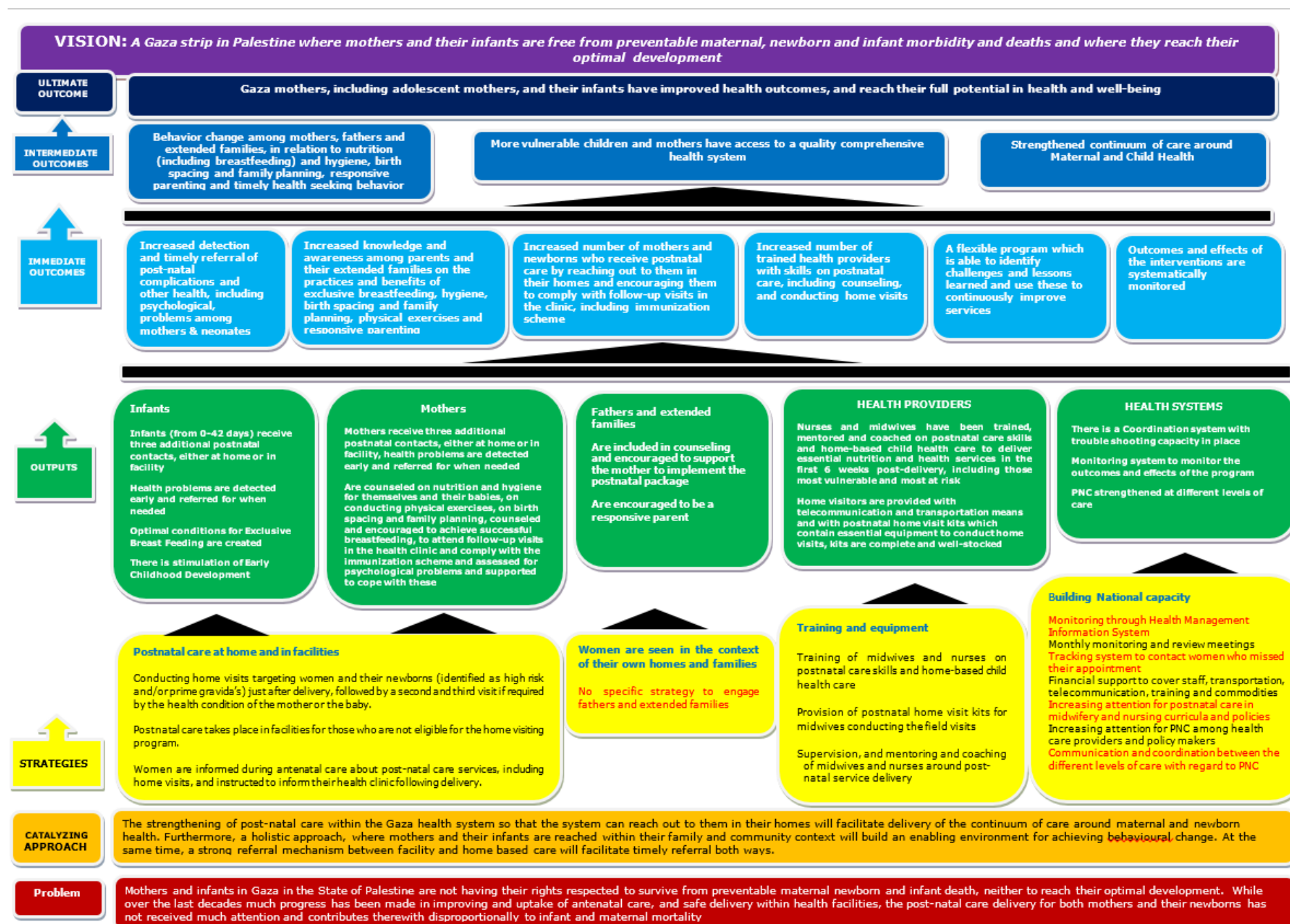
Assumptions/risks

The team has developed a number of assumptions. Most of these assumptions are based on information distilled from stakeholder interviews, as they have not been written down in project documents. During the inception workshop, a sub-group of participants reviewed and endorsed the assumptions. The assumptions have been included in annex 10.

The team has not formulated risks separately, but these are more linked to whether the assumptions hold, such as having a good referral system in place between first and second line services. The assumptions can be found at the foundation of the TOC visual below.

ToC visual

For a visual of the Theory of Change see below



2 Purpose, objectives and scope of the evaluation

2.1 Purpose of the evaluation

The purpose of this external independent evaluation is both summative and formative of character. As stated in the Terms of Reference it has two purposes. Firstly, it is seen as an important opportunity to document and assess the relevance, efficiency, effectiveness, impact and sustainability of the PNHV programme and to inform the MoH, UNRWA, UNICEF and other stakeholders about that. Secondly, identification of good practices and areas for improvement will have to inform future programming and decision making on how to best arrange post-natal care especially in the humanitarian resource constrained context of Gaza.

Furthermore, health actors, such as global Health and Nutrition working groups, will be able to use the evaluation as a case study for programmes that work towards reducing maternal and neonatal mortality. In addition, the findings will be used for reporting and advocacy purposes.

2.2 Evaluation objectives

The evaluation has the following two objectives namely to:

- 1) Assess the relevance; effectiveness; efficiency; impact and sustainability of the PNHV programme against the OECD/DAC criteria (OECD, 2016); and
- 2) Identify lessons learned, including gaps and challenges, and translate findings and conclusions into evidence-informed recommendations that can provide strategic direction to UNICEF SoP, MOH and partners for future programming.

2.3 Scope of the evaluation

The evaluation focusses on the PNHV programme in Gaza. This to better understand how this component has filled the gap in health service provision for mothers with high-risk pregnancies and their new-born who were discharged only within several hours after delivery throughout the Gaza strip. In 2016, the programme covered 12.9 per cent of all live birth in Gaza, and this evaluation therefore – through its quantitative analysis – also provides insight into results of significant numbers of women and their new-borns over the period 2011- 2016.

UNICEF SoP and its partners are keen to learn from the support provided in the past six years, be informed about the impact on Palestinian families and use generated evidence to inform future programming, as well as decision making on how to best proceed with the provision of post-natal care in a resource constrained humanitarian context. For this reason, UNICEF is commissioning an external independent evaluation.

Time

The time period to be covered by the evaluation is from the start of the PNHV in 2011 until the end of 2016, as described in the Terms of Reference (see annex 1).

Geographic scope

The evaluation focusses on all governorates of Gaza, being North Zone, Gaza City, Deir al-Balah or midzone, Khan Younis and Rafah.

Content focus

Content wise, the evaluation focused on answering the evaluation objectives and the wide range of evaluation questions. For more detailed information on this, please see the evaluation objectives, and the detailed evaluation framework.

3 Evaluation methodology

This chapter describes the evaluation criteria used, the methods for data collection, analysis and sampling and the ethical considerations.

3.1 Evaluation criteria and questions

The evaluation framework builds on 1) the expected results and evaluation questions mentioned in the ToR (See Annex 1) and 2) the OECD/DAC evaluation criteria of relevance, efficiency, effectiveness, impact and sustainability. The framework itself can be found in Annex 2

The OECD/DAC evaluation criteria are thereby taken as follows:²²

- *Relevance*: “The extent to which the aid activity is suited to the priorities and policies of the target group, recipient and donor.”
- *Effectiveness*: “The extent to which an aid activity attains its objectives.”
- *Efficiency*: “The extent to which economically resources/inputs (funds, expertise, time, equipment, etc.) are converted into results.”
- *Impact*: “The positive and negative changes produced by a development intervention, directly or indirectly, intended or unintended”
- *Sustainability*: “The extent to which benefits of an activity are likely to continue after donor funding has been withdrawn, both in environmentally as financially terms”

The full evaluation framework can be found below in the annex. Key questions to be answered in line with this evaluation framework are:

Key Questions

- 1. Relevance:** What is the relevance of the PNHV program to both national priorities & strategies, and to the needs of children, mothers, families and communities?
- 2. Efficiency:** To what extent did UNICEF’s work represent the best possible use of available resources (human, financial, other) to achieve results of the greatest possible value to recipients and the community?
- 3. Effectiveness:** Were the objectives of UNICEF’s PNHV program achieved? (Include unintended effects);
- 4. Sustainability:** Are positive results from UNICEF’s PNHV program likely to be sustained?
- 5. Project Impact:** What has been the impact of UNICEF’s PNHV programme on mothers, health workers, families/ communities and others? (With special attention for gender perspectives and for unintended impact)

3.2 Evaluation design

Evaluation approach

In line with the TOR which called for a participatory approach, the evaluation team worked closely with UNICEF SoP representatives and the Evaluation Steering Committee throughout all the evaluation processes. The participatory approach has nurtured the formative nature of the evaluation by

²² OECD. Glossary of Evaluation and Results Based Management (RBM) Terms, OECD (2000).

maximizing learning. It also ensures that the evaluation provides answers to the specific objectives and issues that UNICEF SoP and its stakeholders have.

This evaluation recognizes UNEG Gender related norms and standards, and has made a deliberate attempt to include these in all stages of the evaluation. As evaluators we have ensured that these values were respected, addressed and promoted, and ensured that those most marginalized and most vulnerable perspectives are also included in the evaluation. To reflect the reality from its different perspectives, a triangulated approach was followed utilizing different data collection methods and diverse verification means. This study used a mixed-methods approach involving a desk review and qualitative and quantitative data. The desk review involved reviewing and analyzing reports and statistics about mother health, child health and postnatal care. The quantitative component aimed to obtain more generalizable findings about the program impacts on vital indicators such as mortality rates, contraception use, and also about beneficiaries served, beneficiaries' characteristics, across the different organizations. In order to be able to generate evidence on what has worked well and why or why not, as was mentioned in the ToR and in line with the KIT/Juzoor evaluation proposal submitted and approved, mainly qualitative research methods were used. The qualitative methods focus on bringing together and analysing empirical in-depth data, while the analysis of existing quantitative data focuses on trends in health indicators. The results were triangulated which allowed for multi-layered rich analysis and has reinforced the overall analysis.

In addition, as mentioned in our original proposal, in order to ensure objectivity; transparency; validity; reliability; partnership, accountability and usability, we have followed the following principles during the evaluation:

- None of the evaluation members was involved in the PNHV programme in order to avoid conflicts of interest;
- We have made a clear distinction between facts and opinions of the evaluation team in the evaluation report;
- The evaluation framework and methodology has been agreed upon with key stakeholders (inception phase) before the actual evaluation activities started;
- There has been regular and structured consultation with UNICEF SoP and the Evaluation Steering Committee although this has been somewhat affected by the entire team not being able to visit Gaza during the data analysis workshops;
- Effort has been made to ensure that the outcomes of the evaluation are clear and actionable to inform strategic, policy and programme direction.

Evaluation team

In this evaluation, KIT and Juzoor worked in a consortium with team members that complement each other in their expertise. The KIT team included experts in evaluation, MCH and epidemiology. The KIT team provided oversight and supervision and lead the development of design, analysis and the writing up of this evaluation. The Juzoor team which included experts in public health, MCH and health policy contributed to the design of the evaluation, development of the tools, carried out data collection and contributed to the analysis. Juzoor recruited 6 female data collectors holding master degrees in public health and trained them for 3 days to collect the qualitative data. For more information on the evaluation team and its composition, please see the annex 3.

Evaluation Quality Assurance procedures

KIT has developed a Quality Assurance System related to our ISO9001:2015 certification, which allows us to monitor project management and processes. This system is both for the benefit of our organization as well as our clients as it facilitates continuous improvement of processes. The KIT Management Team is closely involved in the monitoring process. In addition, KIT actively seeks feedback from clients and partners (such as universities, governments, UN and NGOs) to ensure quality, innovation and appropriateness of our products and services.

The evaluation team has also actively sought guidance from the UNICEF convened Evaluation Steering Committee (ESC). The ESC's members played a quality assurance role in reviewing the draft and final evaluation deliverables. A TOR for the ESC can be found in Annex 4. Quality assurance of the evaluation design, field work and evaluation report has been undertaken by UNICEF, in particular the PM&E Specialist and UNICEF H&N team, through critically reviewing deliverables and providing technical guidance/direction as needed.

Quality assurance for the analysis of quantitative data collection follow the KIT Good Epidemiological Practice guidelines, developed in line with the vision of the Responsible Epidemiological Research Practice guidelines from the Dutch Society for Epidemiology (VVE), to increase accountability and transparency of research.

3.3 Data collection methods

Desk review

During the evaluation many documents have been reviewed, including UNICEF area strategy plans and all the programme documents made available by UNICEF. These include work plans from MoH, monthly and annual statistical reports from MoH, NECC and UHWC, program progress forms from the NGO's and training materials (in Arabic). An overall programme proposal from UNICEF from the start of the program in 2011, including overall objectives and log frame does not exist.

Also, desk review of statistical data sources, a literature review on existing evidence for postnatal home visits and, where available, review of national policy and planning documents have been done, in line with what has been indicated in the evaluation framework.

Quantitative data review

Due to the absence of a baseline and control site this retrospective study does not allow a counterfactual quantitative assessment of changes which can be ascribed to the intervention. As described previously, therefore the qualitative data collection have been complemented by a secondary analysis of existing databases. While the design does not enable to attribute changes in trends to the programme interventions, the team aimed to show contribution instead. These large

scale existing data bases have the advantage that data has been collected over a number of years, which allows to trace trend over time.

Data sources include:

- Health Annual Reports 2010-2015 (and 2016 when available)
- MICS 2010 and 2014
- Publications from the Palestinian Central Bureau of Statistics
- PNHV monthly and annual reports from MOH, NECC and UHWC

Secondary analysis of above mentioned data was performed in RStudio²³. Data concerning the home visiting program were extracted from the PNHV annual reports from 2011 to 2015 and compiled in one Excel sheet. Additional data on periodically collected indicators such as exclusive breastfeeding for children under 6 months and yearly registered births were compiled from the Health Annual reports and other publication from the Palestinian Central Bureau of Statistics. Data from the Multiple Indicator and Cluster Survey (MICS) were derived from the UNICEF MICS website²⁴.

Yearly data on the number of women visited by the home visiting program for a 1st, 2nd and 3rd visit were graphed to describe changes over time. Furthermore, the number of women receiving a first visit was set against the total number of registered births to describe a change over time in coverage. This was done for each governorate within the Gaza Strip, but also Gaza Strip as a whole. Data on exclusive breastfeeding of the new-borns of mothers who were visited by the program were also plotted over time to see if there is an increase in exclusive breastfeeding among these women. Changes over time in maternal mortality rate (Palestinian Bureau of Statistics) and neonatal mortality rate (MICS) were graphed, as well as the change over time in indicators such as postnatal care coverage (PNC), EBF in children under 6 months and modern contraceptive use.

MICS data from 2010 and 2014 were used to estimate the number of women who had a live birth in the past two years who were potential candidates for the program as based upon risk factors and complications during their pregnancy (e.g. prime gravida, multiple pregnancy, severe vaginal bleeding etc.) and to describe the frequency of these risk factors among pregnant women and pregnant women with any risk factor. These frequencies were compared to the occurrence of risk factors in women who were visited by the home visiting program to see if there might be women more often overlooked by the program. The same is done for other indicators such as level of education, age of the mother, caesarean sections and sex of the infant.

Finally, using the 2014 MICS data, a logistic regression analysis was performed to characterize women who have experienced a neonatal death. Uni-variable analysis were performed for each of the selected variables. These variables were subsequently put into one multivariable model to see if the associations found in the univariate analysis remain using a 5% significance level. The results of both analyses are reported with corresponding p-value and 95% confidence interval. These models were performed on weighted data to account for the multistage sampling design of the survey.

²³ R Core Team (2017). R: A language and environment for statistical computing. R Foundation for Statistical Computing, Vienna, Austria. URL <https://www.R-project.org/>.

²⁴ <http://mics.unicef.org/>

Qualitative data collection

Based on the tools developed during the inception phase, and after obtaining the official approval/endorsement of the inception report by the UNICEF, data collection took place during the period February 8th through March 10th 2018. A team of 6 female health professionals holding a master degree of public health carried out the data collection. Prior to the actual data collection, a three day training workshop was organized by Juzoor (Annex 5) in April 2018. The training focused on the postnatal period, postnatal care protocols, interviewing skills, recruitment of participants, ethical issues in qualitative research, note taking and data analysis. A pilot study was conducted by the data collection team on a small sample of 6 eligible participants. Subsequently, data collectors conducted pilot interviews in pairs, where each pair has conducted two interviews. A reflection session was organized to discuss the lessons learned from the pilot in terms of selecting participants, the approach for targeting and fine tuning the interview guides.

In-depth-interviews (IDIs) with beneficiaries were conducted at home after contacting the participants via phone and explaining the purpose of this evaluation and explored the consent form particularly voluntary participation. Then, households who agreed to participate were visited according to their convenience. Interviews were conducted with the minimal interference of other family members to enable participants to freely express themselves and their views. When mothers in law or husbands interfered, the team gently asked them not to be present during the interview. Households were visited by one data collector, the average duration of each IDI was around 60 minutes. The response rate was very high, only 5 beneficiaries didn't accept to be interviewed. Interviews were digitally audio-recorded in addition to taking notes. Only one participant refused recording the interview (man).

Focus Group Discussions (FGDs) were conducted at safe Community Based Organizations, located close to where participants live, in a permissive non-threatening environment. Two data collectors have participated in conducting the FGDs. The average number of participants at each FGD was 8 members and average duration was 2 hours. FGDs were audio-recorded in addition to taking notes.

With regard to the KII interviews, policy makers were interviewed at their offices and the average duration of the interview was 60 minutes. All of them positively responded and agreed to participate and to digitally record the interview.

Interviews were transcribed and directly translated into English.

Research data collection tools

The tools prepared by the research team are based on the evaluation matrix, as well as questions related to the reconstructed ToC. The drafted tools were shared with the steering committee as annex to the inception report, endorsed by UNICEF and then piloted in the field prior to the data collection. The questions were phrased as open ended in order to allow participants to express their views with possibility for additional probing by the data collectors. The topics guides for interviews and or focus group discussions with beneficiaries (mothers), fathers, midwives and nurses and key stakeholders can be found in Annex 6.

3.3 Sampling design

In total, at least 130 persons were interviewed during the data collection phase in addition to the ones who have been interviewed during the inception phase (11) and the pilot (6 respondents). Figure 4 shows the distribution of tools administered during the actual data collection for this evaluation.

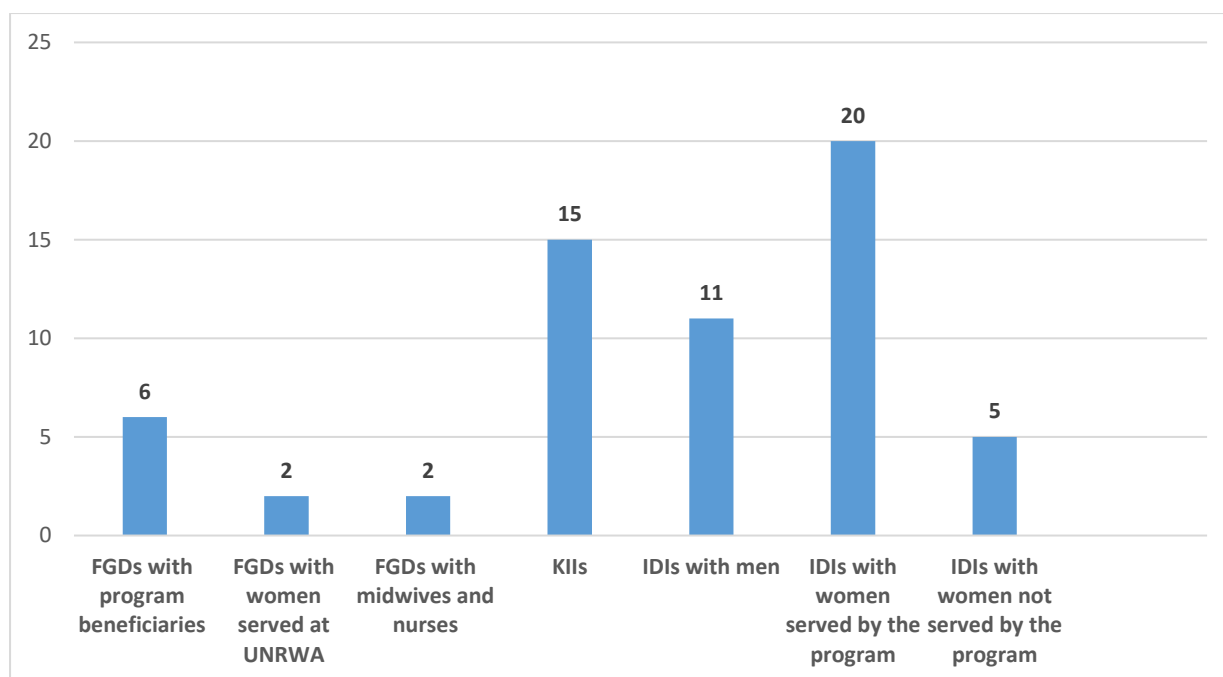


Figure 4 Distribution of methods implemented during the data collection

The conducted IDIs were divided as follows: 20 with women beneficiaries, who have been visited at home through the program (four from each governorate); 5 women served at health centres and not visited at home despite being high risk cases (one from each governorate), and 11 husbands of women who have received postnatal care at home.

The team also interviewed a wide variety of key informants at different levels (15 KIIs). These included **policy-makers from the Ministry of Health, local NGO representatives, and staff from international organisations, including UNICEF, WHO, UNFPA and UNRWA**. The distribution of the KIIs was as follows; 5 from governmental sector, 5 from NGO sector and 5 from the international organization. The final list of key informants interviewed can be found in Annex 8.

Additionally, 10 FGDs were conducted with women who benefited and women who did not benefit from the home visiting program, and also with service providers who conducted the home visits. The evaluation team organized six FGDs with women targeted by the program and visited at home, and 2 FGDs with women who haven't been targeted by the program, despite being high risk cases, they have been served at UNRWA clinics, and haven't been visited at home. In addition, two FGDs were organized with the midwives and nurses who are conducting the home visits to get insights about their perspectives about the home visits. This wide range of participants has enriched the qualitative data and strengthen triangulation.

Sampling selection

Table 3 Respondent overview

Type of tool		Number of participants	Percentage
8 FGDs with women beneficiaries and non-beneficiaries	6 FGDs with women beneficiaries and non-beneficiaries	48	37
	2 FGD with high risk women who haven't been visited (UNRWA)	14	11

2 FGDs with service providers (nurses and midwives)	<ul style="list-style-type: none"> • One in the central and the north of Gaza • One in the south 	17	13
KIIs	<ul style="list-style-type: none"> • 5 from governmental services • 5 from UN agencies • 5 from NGOs 	15	12
IDIs with women & men (7 from each of the 5 Gaza governorates)	Women Beneficiaries of the program	20	15
	Women Not served by the program-served at the clinic	5	4
	Husbands of women served by the program	11	8

Beneficiaries of FGDs and IDIs were selected from the medical records, in agreement with MoH, NECC and UHWC. The evaluation team provided these organizations with the selection/inclusion criteria and they provided lists of beneficiaries from which we purposively selected the participants. The sampling from medical records is to ensure that the voices of all type of beneficiaries are reflected and not the success stories only. Furthermore attention was given to ensure all geographic areas are covered and all type of inclusions for the program are represented, i.e. high-risk cases identified during pregnancy, prime gravida and high risk cases as a result of a complicated delivery, caesarean section versus vaginal deliveries and many others. Respondents should have delivered a baby 3 to 18 months prior to the interview or FGD (women who have been visited during the period August 2016 through October 2017). The 3 months barrier is set because women need to have gone through the whole postnatal period, the 18 months barrier is to reduce the bias due to a long recall period. It is realized that this period of time does not cover the full 6 years from 2011 to 2016 and will even include women that delivered in 2017. However, because the programme is continuously evolving and there is a priority to know how and if the programme works in order to inform future planning, this sampling method for the qualitative data should be appropriate, while quantitative data will be better able to show trends over time, and therefore cover the whole evaluation period. Some women might have delivered more than one baby over the past seven years, this will help to include beneficiaries' perspective on changes over time.

The male spouses who were interviewed are not the spouses of the women who have been interviewed, in order to include a wider perspective, adhere to ethical principles and possibly avoid marital problems. To select the sample for the focus groups with the service providers (midwives and nurses), MoH, NECC and UHWC were requested to provide lists of staff who are involved in the programme and the evaluation team selected diverse participants in term of profession, years of experience, localities they serve, organizational affiliation and others.

As table 4 depicts, the majority of participants who have been interviewed were females (around 88%), 61% of beneficiaries were non-refugees, as refugees are usually served by UNRWA and receive services at the agency's health facilities. Nearly half of the interviewed beneficiaries were served by MOH, 25% were served by NECC and the rest by UHWC. This distribution is congruent with the beneficiaries targeted by the programme at these organizations. Beneficiaries belonged to large families with a median of 7 members per family. The median age of interviewed woman was 30 years and the median schooling years was 12. With regard to obstetric history, women were diverse as follows; 34% were prime-Para, 40% delivered via CS, 45% had experienced complicated labour and almost two thirds were high risk pregnancies. Both visited and non-visited women (19%) were included, 52% were visited once and 17% were visited twice (see table).

Table 3 Respondent demographics

Respondent demographics – 130 persons interviewed and or involved in FGDs		Number of participants	Percentage
Sex of all participants (beneficiaries and KI)	Males	16	12.3
	Females	114	87.7
Sex of beneficiaries	Male	11	11.2
	Female	87	88.8
Refugee status	Refugees	38	39
	Non-refugees	59	61
Sector at which women were served	MOH	47	48
	NECC	25	25.5
	UHCW	10	10.2
	UNRWA	16	16.3
Family size of participants	Up to 5 member	39	39.8
	6-10 member	43	43.8
	More than 10 members	16	16.4
	Median family size	7 members	
Age group of beneficiaries	Up to 25 years	34	34.7
	26 to 30 years	22	22.4
	30 to 35	18	18.4
	36 and more	24	24.5
Median age of interviewed women beneficiaries		30 years	
Median level of education		12 years	
Parity status	Prime Para	34	34.7
	Multipara	64	65.3
Mode of delivery	Caesarean section	40	40.8
	Vaginal delivery	58	59.2
Experiencing complicated labor	Yes	45	45.9
	No	53	54.1
Experiencing High risk pregnancy	Yes	62	63.3
	No	36	36.7
Number of home visits conducted	None	19	19.4
	One	51	52.0
	Two	17	17.3
	Three and more	11	11.2

3.4 Data analysis

Qualitative analysis was applied continuously throughout data collection process. As mentioned earlier, extensive notes were taken from interviews, and FGDs. Immediately, after each interview/FGD a debriefing report was prepared to capture the big ideas and main issues discussed during the interview. Digitally recorded interviews and FGDs were transcribed and translated into English. Notes and transcripts were reviewed for emerging themes, completeness of work and inconsistencies. The evaluation framework and the ToC have been used to develop a coding framework. Notes, debriefing reports and transcripts were all organized in NVivo software and subsequently analysed.

The original plan was to conduct an analysis Workshop with the participation of KIT team, unfortunately, because of the security situation, it wasn't possible for them to visit Gaza and work with the data collection team in person. Alternatively, a long debriefing session was organized with participation of KIT team and the data collectors, at which, major issues and themes that emerged during the interviews were discussed and documented.

Secondary **quantitative data analysis** was supported by our epidemiologist, using the available large scale data bases and HMIS data. The secondary data were analysed in Stata. The analysis framework for this was the evaluation framework and the ToC developed during the inception phase; however, due to the limitations in data availability, it wasn't possible to do more quantitative analysis.

3.5 Limitations

The methodology faces several limitations. These include:

- The absence of a baseline and or a control site and therewith a counterfactual, as this made it difficult to precisely attribute the change in health indicators or in mother practices to the home visiting programme. We filled this gap by conducting literature review and secondary analysis of the available data. In addition, both neonatal and maternal mortality are relatively rare occurrences, so even with a large dataset the number of neonatal deaths or maternal mortality are low, making them difficult to analyse.
- It is not possible to attribute any changes over time to the program. Nevertheless the analysis provides insight in efficiency and effectiveness of the home visiting program by triangulation of data from multiple sources one of which is a largescale nationally representative survey being the PCBS MICS survey.
- The absence of a Theory of Change or program description document at the onset of the programme. The reconstructed Theory of Change is mostly based on interviews and program work plans and has helped in providing guidance for data collection, analysis and identifying successes and gaps of the program.
- Due to lack of adequate documentation, recruitment of participants served by the MOH was very complicated for various reasons: the lack of electronic database, lack of contact details of beneficiaries, lack of monitoring data/reports and inaccurate documentation. There is no proper registration of who is actually visited; it is therefore difficult to verify whether women have been visited or not. Some women approached for interviews said they had not been visited although a home visit card was given to the data collection team. The evaluation team used all the possible identification data to reach beneficiaries which was major time consuming work.
- Despite collecting very useful data during the home visits, these were not appropriately managed and therefore finally lost. This affected the ability of the evaluation team to conduct secondary analysis of the data and to infer any possible effects as a result of participation in the programme. Data available from the programme are presented in monthly and annual statistical reports. This data is collated and not linked to individuals, raw data is not available. The reports provide data on output level, but hardly on outcome level.
- Data in the PNHV annual reports was incomplete for 2011 to 2016 and therefore not all years could be included in all analysis. Furthermore, this data was not uniform for each year and was therefore not always comparable to one other. For example, the report from 2011 only shows the total number of home visits, but not how many of those visits were first, second or third home visits. Another example are the inconsistencies in numerators and denominators, e.g. family planning in 2011 reported as proportion of women are on a method, in 2012 not reported at all and for other years reported as the proportion of women who want to use a family planning method.

- The team tried to minimize the recall bias, by selecting respondents who delivered 3-18 months prior to the interview or FGD. A consequence is that qualitative data collection from beneficiaries from the programme will not cover the full period 2011-2016.
- Also data from the MICS is based on recall and therefore prone to recall bias, women were asked about their last birth and pregnancy in the 2 years preceding the survey and might simply not recall specific events.
- The evaluation of efficiency of the program, including cost-effectiveness, requires more detailed information and access to UNICEF financial reports, indicating how money was spend and products purchased. Only work plan budgets and program progress reports from MoH and the NGO's are available. A full financial overview of the program, including total expenses for UNICEF to run the program, has not been made available, therefore this part was skipped.

3.6 Ethical and UNEG standards

Research ethics approval for this evaluation has been obtained through the UNICEF Regional Office in Jordan from the HML Institutional Review Board in Washington, please see annex 9 for the approval letter. During the evaluation we have taken care to strictly adhere to the approved protocol, which in turn follow the ethical standards for evaluation as documented in the UNEG Ethical Guidelines for Evaluation of March 2008, the UNEG Ethical Guidelines for Evaluation²⁵²⁶ and the UNICEF Procedure for ethical standards in research²⁷. These documents refer to ethical principles in evaluation, covering intentionality of the evaluation, obligations of evaluators, obligations to participants, evaluation process and product.

With respect to ethical standards while consulting with clients of the programme, as well as with other stakeholders, we strictly adhered to the following principles:

- a) avoiding harm or placing respondents at undue risk, this amongst others were maintained by ensuring that FGDs and or interviews had been carried out at places that are both safe and convenient for the participants, and by not interviewing spouses, see further below;
- b) working towards beneficence of the respondents by generating evidence on how well-being can be promoted; respecting confidentiality and anonymity, including through safe storage of interview data (notes, tape recordings, transcripts; for more details see below);
- c) respecting the right to not participate without adverse effects and avoiding of undue influence or coercion by making participation really voluntary and not offering payment which may cause that people feel tempted to participate against their will;
- d) right to full information on the evaluation by informing them prior to the interview (see informed consent form; and by including in the dissemination plan a strategy for informing beneficiaries/respondents;
- e) respect for each participant or the participant's legally authorized representative through informed consent forms. We included women who had had risk pregnancies and who - at the time of the interview – were 18 years or older, therewith there was no need to obtain informed assent from minors.

²⁵ <http://www.uneval.org/normsandstandards/index.jsp>

²⁶ <http://www.unevaluation.org/ethicalguidelines>

²⁷ UNICEF, PROCEDURE FOR ETHICAL STANDARDS IN RESEARCH, EVALUATION, DATA COLLECTION AND ANALYSIS
Document Number: CF/PD/DRP/2015-001, Effective Date: 01 April 2015, Director, Division of Data, Research and Policy (DRP)

Furthermore, all data collected were kept confidential by ensuring that transcripts were only typed up in computers which are protected by login codes, and by not including the name of the participants in the transcripts. Tapes were kept under lock and key and destroyed as soon as the transcripts have been developed and checked. Transcripts will also be destroyed once the evaluation has been completed. Informed consent forms (which contain the names of respondents), notes and tapes are kept separately from each other. The secondary quantitative data is all anonymized as it comes from service providers aggregated or anonymized (coded).

All data collectors have taken a course at university on Ethics, and as result have international research ethics certificates. However, they also received an intensive refresher training on how to respect all ethics principles, mentioned above, prior to the data collection. They were also trained in how to take informed consent from the respondents and how to ensure the FGDs and interviews take place in for the respondents comfortable and safe places. In addition, as has been mentioned before, husbands of women having participated in the program were not those of women who participate in the FGDs and interviews themselves. This to further protect their confidentiality. They were also trained in how to refer those who are in need of (emotional) support to the appropriate services. This training has been provided by evaluation team members with extensive experience in providing such training. The informed consent forms that have been developed for this evaluation, and have been translated into Arabic, have been included in annex 7.

4 Evaluation Findings

This section of the report focuses on the findings of the evaluation, and brings together qualitative interview data, re-analysed secondary quantitative data, as well as data from the document review. The evaluation framework has been used as an outline to describe the findings.

4.1 Relevance

The relevance chapter aims to answer the following evaluation question: ***What is the relevance of the PNHV program to both national priorities & strategies, and to the needs of children, mothers, families and communities?***

4.1.1 Size of maternal and neonatal mortality at start of the program

The 2010/11 maternal and neonatal mortality rates in Gaza justify the introduction of the PNHV programme in 2011. The overall MMR ratio in Gaza fluctuated between 28 and 29.4 per 100,000 live births in the period 2008 – 2011, indicating a need to take measures to improve maternal health.

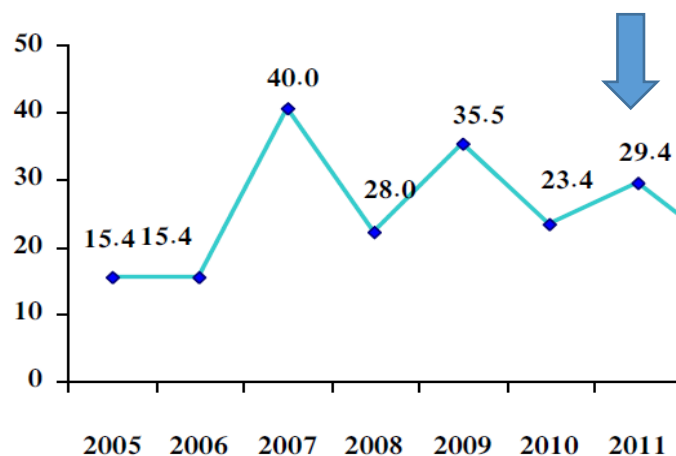


Figure 5 MMR trends in Gaza between the years 2005 through 2010/11. Source: ²⁸

Thereby it has to be taken into account that the data on maternal mortality have quality issues. A MOH and UNFPA study (2011) indicated that the underlying cause of maternal death was inaccurate in 40.7% of death certificates, while pregnancy status was not clarified in 44.4% of the certificates belonging to deceased women.

The leading causes of maternal deaths in Palestine include haemorrhage, hypertension, embolism, sepsis and death of associated diseases especially cardiac diseases (MOH, 2011)²⁹. In 2016, the leading causes of maternal mortality in Gaza specifically were cardiac arrest (45%), haemorrhage (27.5%) respiratory problems (18%) and septicaemia (9%). The highest maternal mortality was observed with increased age of mothers (above 30 years), during the postpartum period, and when caesarean section was the mode of delivery. Around 18% died at home and the rest at hospitals³⁰.

²⁸ Ministry of Health (2016) Mortality Report in the Gaza Strip. Gaza: Palestinian Health Information System. Ministry of Health

²⁹ MOH and UNFPA (2011), Assessment of Maternal Mortality in the Gaza Strip 2008-2009. Gaza

³⁰ Ministry of Health (2016) Mortality Report in the Gaza Strip. Gaza: Palestinian Health Information System. Ministry of Health

Maternal mortality is known to represent the “tip of the iceberg”. Tabassum Firoz et al has estimated that for each case of mortality, 20 to 30 cases of morbidity develop.³¹ There is no precise morbidity estimates for Palestinian women. Published reports indicate that the most commonly reported health problems during pregnancy are: infections (urinary tract infections and reproductive tract infections), anaemia and pregnancy induced hypertension³². Shanan (2014) reported that the causes which led to the near-miss scenario in Gaza included severe haemorrhage 70.8%, hypertension 16%, uterine rupture 3.7%, sepsis 3.7%, and HELLP 3.7%.³³

The most frequently reported estimation of Infant Mortality Rate (IMR) has been around 20-22/1,000 live births in the GS (PCBS, 2015)³⁴. Most infant deaths are neonatal deaths. The 2010 MICS shows that 11 new-borns out of every 1000 live births died within their first 28 days of life. With close to 60,000 deliveries in 2010, this provides a very rough guestimate of around 600 neonatal death in that year.

Most neonatal deaths are early neonatal deaths meaning they die in their first week of life, mainly resulting from prematurity related conditions, respiratory conditions, sepsis and congenital anomalies (MOH 2016)³⁵. Many of these conditions can be addressed through tackling the neonatal maternal conditions particularly those related to the contextual situation.

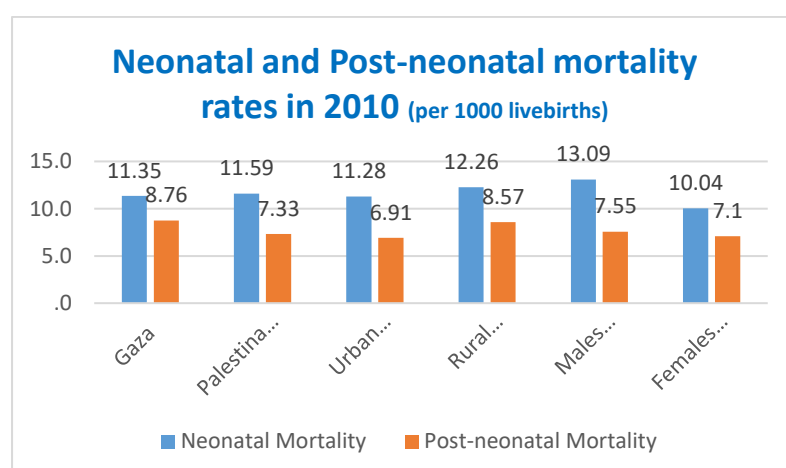


Figure 6 Neonatal and post-neonatal mortality rates. Source: PCBS MICS 2010 .

In 2010, the neonatal mortality rate was somewhat lower in Gaza than in WB in 2010, but the post-neonatal mortality (28 – 365 days of life) slightly higher. In Palestine, neonatal and post-neonatal mortality is higher in rural areas, and higher among male than female babies as can be seen in the graph above.³⁶

³¹ Tabassum Firoz et al (2013), Measuring maternal health: focus on maternal morbidity <http://www.who.int/bulletin/volumes/91/10/13-117564/en/>

³² Ministry of Health (2016) Mortality Report in the Gaza Strip. Gaza: Palestinian Health Information System. Ministry of Health

³³ Shanan, Y. (2014), Risk Factors for Maternal Near miss in Gaza Strip: Case Control Study. Master thesis Al- Quds University

³⁴ Palestine Central Bureau of Statistics (2015) Palestinian Multiple Indicator Cluster Survey 2014, Final Report. Ramallah: Palestine Central Bureau of Statistics.

³⁵ Ministry of Health (2016) Mortality Report in the Gaza Strip. Gaza: Palestinian Health Information System. Ministry of Health

³⁶ Palestinian Central Bureau of Statistics. *Palestinian Multiple Indicator Cluster Survey 2010*. Ramallah, Palestine.

4.1.2 Gaza's performance in terms of MDG's and national strategies

Millennium Development Goal 5 aimed to improve maternal health through the reduction of maternal mortality and improving the proportion of births attended by skilled health personnel over the period 1990 and 2015³⁷. The overall MMR ratio in Palestine significantly improved over time, from more than 55 per 100,000 live births in 1999 to around 23 in 2014, with an annual reduction of 3.6%, 1,9% short of the MDG5 target of 5.5% annual reduction.³⁸

As mentioned in the background section of this document, almost all births in Gaza are attended by skilled health personnel, close to 75% by a physician and 25% by a midwife/nurse³⁹. Around 70 % of deliveries take place in MoH hospitals, 27% in NGO facilities, and the rest in the private sector and military health services. Unlike in the WB, UNRWA does not provide natal services in Gaza. Delivery through caesarean section has increased from 15% in 2006 to 19.0% in 2015, above the recommended WHO standard of 15%. This is said to be influenced by lack of clear policies and protocols and over-medicalization of the obstetric services.

More than half of the women in Gaza leave the facility within six hours after delivery, even after only 2 or 3 hours of having given birth⁴⁰. This strongly affects opportunities to provide comprehensive post-natal care for both mother and new-born in the first few hours before discharge from the hospital. Post-natal visits are in-frequent in number and mainly linked to the BCG vaccine given to the newly born in the health facility; usually only one visit is utilized, in case it is conducted, and it provides much less attention to the mother of the new-born.

Millennium Development Goal 4 aimed to improve child health by reducing under-five mortality rate. While globally progress was made in reducing the under-five mortality rate, the contribution of neonatal mortality to under-five mortality increased over time. In 2013 neonatal mortality was globally responsible for 44% of under-five death.⁴¹ In Palestine, under-five mortality in Palestine dropped from 42 to 22 death per 1,000 live births over the period 1990-1994 to 2010-2014. In spite of this reduction by half, this drop is still short of the MDG 2015 target of 18 deaths per 1,000 live births.⁴² In Gaza, the majority of child deaths occur during the first year of life, and particularly in the first 28 days (the neonatal period), which account for 61 per cent of deaths in the first year.⁴³ The neonatal mortality rate is 11 deaths per 1,000 live births and the postnatal mortality (1-11 months) rate is 7 per 1,000.⁴⁴

³⁷ WHO (2008). Millennium Development Goal 5, Fact sheet

http://www.who.int/maternal_child_adolescent/events/2008/mdg5/mdg5_vs3.pdf

³⁸ Ministry of Health (2016) Mortality Report in the Gaza Strip. Gaza: Palestinian Health Information System. Ministry of Health

³⁹ Palestinian Central Bureau of Statistics. *Palestinian Multiple Indicator Cluster Survey 2014*. Ramallah, Palestine. Published in December 2015

⁴⁰ Palestinian Central Bureau of Statistics. *Palestinian Multiple Indicator Cluster Survey 2014*. Ramallah, Palestine. Published in December 2015

⁴¹ WHO http://www.who.int/topics/millennium_development_goals/child_mortality/en/

⁴² PCBS, UNICEF and UNFPA, (2015). *Palestinian Multiple Indicator Cluster Survey 2014*, Palestine

⁴³ PCBS, UNICEF and UNFPA, (2015). *Palestinian Multiple Indicator Cluster Survey 2014*, Palestine

⁴⁴ PCBS, UNICEF and UNFPA, (2015). *Palestinian Multiple Indicator Cluster Survey 2014*, Palestine

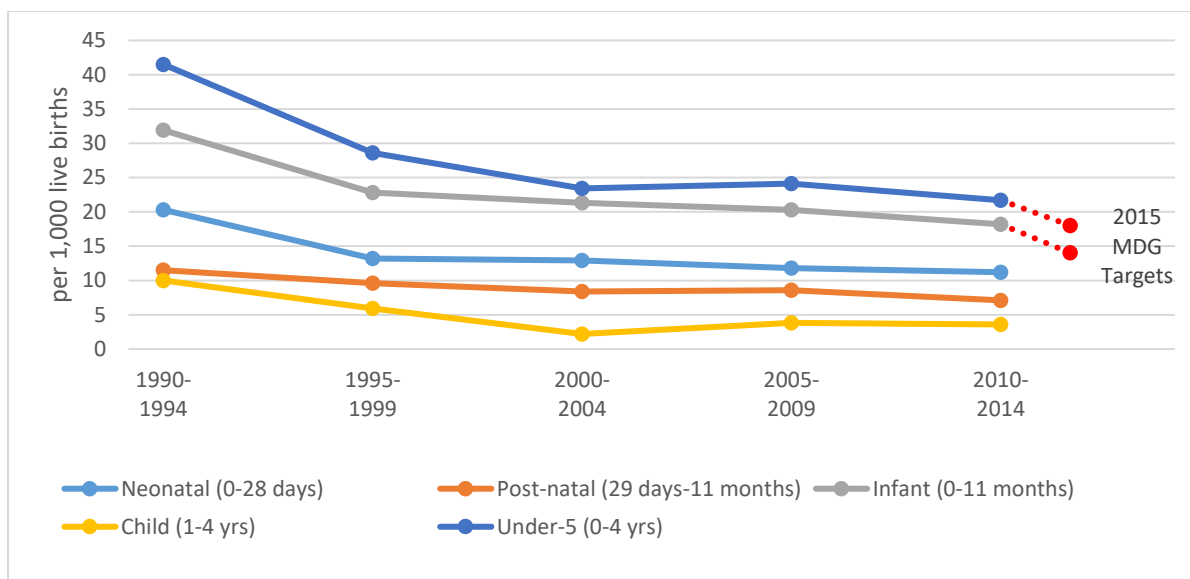


Figure 7 Trends in early child mortality in Palestine, 1990 - 2014. Source: UNICEF Situational Analysis 2016.⁴⁵

National strategies

The Draft National Health Strategy 2017 – 2022 of the Ministry of Health of the State of Palestine intends to reform primary health care by introducing a family medicine approach with a strong focus on families and communities when targeting reproductive health, mother and child health, school health, community health and health education services. This new strategy however, only mentions postnatal care once as part of the plan to “Support and develop mother and child care services, maternal care, postnatal care and family planning services”⁴⁶, but does not provide any further details and does therefore not make reference to home visits as part of PNC. The Health Sector Strategic Plan 2014 – 2018 acknowledges that while there has been an increase in postnatal care from 19.7% in 1996, to around 40%, the quality of postnatal care services is an issue.⁴⁷ The plan also indicates the need to improve coverage as well as the quality of postnatal care in hospitals, homes and at PHC centres and indicates funding having been put in place. Responsible bodies to work on this are the Primary Health Care Directorate, UNRWA, Palestinian NGO Network, the Health Education Department and the Hospitals Directorate.

The draft UNICEF Situation Analysis states that there are gaps in national policies for maternal and new-born care, including in relation to home visits and early detection of developmental delays and disabilities. The Situational Analysis also states that a directive has been issued to all hospitals in Gaza that mothers must not be discharged within less than 6 hours of birth⁴⁸.

MoH of Palestine with support of a MCH project supported by USAID, developed the Postpartum Care Protocols in 2004⁴⁹ and accompanying post-partum care training curriculum⁵⁰. The components of postpartum care described in this protocol are in line with the objectives of the home visits in the

⁴⁵ UNICEF Situation Analysis of Children Living in the State of Palestine (Draft), 2016

⁴⁶ GDHPP MoH SoP, Draft National Health Strategy 2017 - 2022

⁴⁷ MoH. Health Sector Strategic Plan: Gaza Governorates 2014 - 2018

⁴⁸ UNICEF Situation Analysis of Children Living in the State of Palestine (Draft), 2016

⁴⁹ Palestinian National Authority Ministry of Health. Postpartum Care protocols, November 2004.

⁵⁰ MARAM. Postpartum Care Training Curriculum, March 2005.

PNHV program. The protocol does not give direction about the timing of postnatal contacts, but is clear about the 6 hours post-delivery in facility, the health education and counselling which should be provided before discharge and includes a chapter on 'care of the woman during the third day home visit', indicating that home visits are part of the Palestinian PNC protocol.

4.1.3 UNICEF's support in line with national priorities and strategies

Postnatal home visits in Gaza are not entirely new nor exclusively addressed by UNICEF's PNHV programme. The PNHV programme was a reintroduction of a home visiting programme that had stopped due to lack of resources five years prior to the current PNHV programme came into being. The reintroduction was inspired by the fact that there was stagnation in improvements around infant and child mortality, in combination with the evidence that two third of infant mortality was related to neonatal mortality, especially in the first week of life. This in combination with the fact that postnatal care was perceived as an important caveat in the performance of the health system.

The PNHV programme was re-introduced in a context in which postnatal and neonatal mortality was receiving more attention. In 2008, the countdown to the 2015 initiative called for strengthening of Post Natal Care (PNC) services and better data availability and quality on this topic, in an attempt to achieve the MDG targets to reduce maternal and neonatal mortality.

Many key stakeholders interviewed, including those within the MoH, confirmed that it is highly relevant to strengthen postnatal care within Gaza, as there is wide recognition that neonatal mortality disproportionately contributes to infant and under five mortality. Also many stakeholders in Gaza acknowledged that in a setting where women leave the hospital shortly after delivery, a home visiting programme within the first 72 hours can contribute to the identification of complications.

"So if we care for these cases in the first 72 hours we can protect mothers from maternal death. Home visits... are very important, because mothers come to the clinic only for the first vaccination for the child (after one week or more) so postnatal home visits is the basic to protect mothers from maternal death". – IDI Stakeholder

The PNHV programme is also in line with the WHO recommendations on postnatal care where home visits in the first week after birth are recommended for care of the mother and new-born.⁵¹ As explained earlier, the PNHV programme thereby focuses on high-risk cases only as there are not enough resources to provide universal coverage.

4.1.4 Demands and needs of mothers and their infants, spouses and families

Most women who had been part of the PNHV programme said that they had experienced the visit as something very useful for them, and that it was much better than having to go to the clinic. They provided a number of reasons for this. Many felt reassured through the visit that everything was fine with the baby, and also felt more precious as result of the fact that somebody had taken the trouble to visit them. Many stressed that as result, they really liked the visit, as can be seen from the quote below.

'Yes I am so happy, because they reassured me on the baby'- FGD visited mothers Gaza Others said that they had learned a lot from the home visits, especially around breastfeeding, but also around traditional hygiene practices.

⁵¹ WHO (2013). Recommendations on postnatal care for the mother and the new-born.

http://www.who.int/maternal_child_adolescent/documents/postnatal-care-recommendations/en/. Recommendation 3.

Many of those with Caesarean sections said that they would not have been able to travel to the clinic for postnatal care.

“The home visit was much better than going to the clinic, especially for me, since I live in a multi-story building and it would be difficult to go” - Female respondent with a caesarean section

A number of respondents talked about living very far from the clinic and not having the resources to pay for transport to go, which would make them default postnatal care. Yet others said that because of having more children to take care of at home, they are not able to go to the clinic for postnatal care.

Women also talked that during the home visit they receive more personal attention than during clinic visits, and that the nurse in the homes provided more tailor made advice. A respondent said in this regard:

“In the home she saw me in my natural environment. She noticed that I was coughing. She showed me way how to cough so as not to suffer from the stitches. In the clinic she would not notice that I was coughing and I would not tell her”. - Female respondent with a caesarean section

Many of the women interviewed were of the opinion that it is not necessary to go for care for themselves to the clinic. They would only go for immunization of the baby but not for a check of their own health. They also talked about the crowdedness in the clinics which would cause them to wait a long time.

Some women however felt that they did not receive enough health education during the visit, that the visit was too short, that the midwife did not provide proper care because of not having checked stitches, or that they were not enough encouraged to ask questions.

Spouses and other family members overall are supportive of the home visits, and think that it is of benefit to women and neonates. They also indicated that it is often hard for a women who has just delivered to go to the clinic for a postnatal check, especially during the first few postnatal days due to their tiredness

4.1.5 Demands and needs of nurses and midwives trained as home visitors

The midwives interviewed talked about the fact that because of the PNHV programme they have had the opportunity to learn more about what is happening in the communities and in families, and to have obtained a better understanding of clients contexts and culture. In addition, because of the monthly project meetings, they have also had the opportunity to exchange information and learn from that. This contextual information helps them in building a better relationship with their clients.

“for me the benefit was knowing a lot of people, exchanging experiences between us, I was introduced to their culture, during my previous visits and up to the near time, I faced many false traditions especially for the umbilicus they used oil and salt for it or antibiotic capsule and many false things which we changed to the right way, and some ladies who are not followed up at my clinic for example at UNRWA's clinic they seek our helps and asking me how to help them in breast feeding. Honestly the project is good for people.” – FGD health providers south & midzone

Further, through the programme they have received additional training, and financial support (for travel), although also additional training needs were mentioned such as around psychological support

and dealing with the ones most vulnerable. This will be further dealt with in the efficiency section of the report.

There was a wide variation in logistical needs of the midwives/nurses depending whether they worked for MoH, NECC or UWHC. MoH midwives often times have to arrange their own transport while transport was provided by NECC and UWHC. MoH midwives also had to work alone which made them feel insecure especially in unknown farther away settings, while NECC midwives are accompanied by a driver which provided more security. UHWC midwives initially also worked by themselves, but because of working in an area which had safety issues, they changed this to teams of two nurses. Many of the MoH midwives/nurses mentioned that home visits is not easy and that it comes on top of their other work. Several MoH midwives/nurses also mentioned that their husbands did not like that they visited other people's houses.

MoH Midwives also talked about being annoyed by people contacting them over phone after the visit when they had problems. This lead many midwives to regularly change phone. Also mentioning was made that there was a lack of replacement of equipment such as a portable haemoglobino-meter and gloves.

4.1.6 Relevance and selection of stakeholders

The principal stakeholders are women with high risk pregnancy and prime para women. The focus on these two groups is because of a lack of resources to provide home visits to all women who have delivered. It is believed that these two groups have the highest need for home visits, this because of their elevated risk for complications and prime para women being inexperienced care providers. The criteria for high-risk are described in the introduction under program description (Table 2 Risk Assessment according to MCH handbook). Apart from the medical risk assessment there is no social/vulnerability risk assessment.

In order to assess what risk factors are associated with neonatal death in Gaza, the evaluation team performed a logistic regression analysis (Table 4). The outcome variable was neonatal death (yes/no) and the following independent variables were included in the analysis: prime gravida, residency, wealth quintile, mother's educational level, number of children of mother, age of mother at first birth and sex of infant. First, a univariate logistic regression analysis was performed to estimate the association between a single variable and the outcome. Second, multivariate analysis was performed including all independent variables. Odds ratios (OR) are reported with corresponding p-values and 95% confidence intervals. The analysis is performed on weighted observations in order to account for the sampling approach that was used by the MICS for household selection. The multivariate regression analysis was not able to identify specific risk factors associated with higher neonatal deaths.⁵²

⁵² First child birth seems associated to neonatal death in the univariate analysis. The first child of a mother has a 1.53 higher odds on dying within the first month of life than children from later deliveries. However, this association is no longer significant in the multivariate analysis which indicates that this association is likely to be confounded by other variables. Furthermore, new-borns born to a mother with primary education have a higher odds (OR:1.62, p-value<0.05; aOR:1.81, p-value<0.05) on dying in the first month of life than new-borns who are born to a mother who has received highest education in both the univariate and multivariate analysis. However, overall, mother's level of education does not seem to significantly risk neonatal death. All other variables (e.g. sex of infant, number of children, residency etc.) do not seem significantly associated to neonatal death in either the univariate or multivariate model.

Table 5 Univariate and multivariate logistic regression analysis of neonatal deaths

Variable		Univariate		Multivariate	
		OR	95%CI	aOR	95%CI
Prime gravida	No (Reference)	1.00 (0.01)		1.00(0.07)	
	Yes	1.53*	(1.09 - 2.15)	1.43+	(0.98 - 2.08)
Residency	Urban (Reference)	1.00 (0.89)		1.00(0.88)	
	Rural	0.85	(0.35 - 2.06)	0.93	(0.37 - 2.31)
	Camp	0.93	(0.63 - 1.37)	0.9	(0.60 - 1.35)
Wealth quintile	Poorest (Reference)	1.00		1.00	
	Second	1.11	(0.78 - 1.58)	1.13	(0.80 - 1.61)
	Middle	0.46+	(0.20 - 1.04)	0.51	(0.22 - 1.14)
	Fourth	0.83	(0.27 - 2.56)	0.86	(0.28 - 2.67)
Mother's educational level	Richest	NA	NA	NA	NA
	Highest (Reference)	1.00 (0.20)		1.00(0.11)	
	Secondary	1.16	(0.80 - 1.67)	1.25	(0.84 - 1.85)
	Primary	1.62*	(1.01 - 2.60)	1.81*	(1.10 - 2.98)
Number of children	None	0.54	(0.07 - 3.87)	0.58	(0.08 - 4.18)
		1.00 (0.10)		1.00(0.11)	
Age of mother at first birth		0.93+	(0.86 - 1.01)	0.93	(0.86 - 1.02)
		1.00 (0.78)		1.00(0.74)	
Sex of infant		0.99	(0.95 - 1.04)	0.99	(0.94 - 1.04)
	Male (Reference)	1.00 (0.31)		1.00(0.41)	
	Female	0.86	(0.64 - 1.15)	0.88	(0.66 - 1.18)
Total number of observations		13440		13408	

+ p-value<0.10, * p-value<0.05, **p-value<0.01, ***p-value<0.001. ; Performed on weighted data to account for multistage sampling approach

Other program stakeholders are the MoH, NECC, UHWC and UNWRA. Postnatal home visits as conducted by MoH's Women Health and Development Department (WHDD) were first implemented in 2000 for high-risk cases and expanded in 2002 to include prime- and grand multigravida. Financial support came from the Italian cooperation and later UNFPA. Due to funding barriers the program stopped in 2004, until UNICEF started refunding in November 2010/11.⁵³ The PNHV started in 2011 with MoH as implementing partner. After some time the need for scale up was realized, and since 2014 funding was also provided to NECC to improve their already existing postnatal home-visit services. NECC had conducted postnatal home-visits for their target population in around 3 PHC clinics since its founding in 1952. After the partnership with UNICEF, NECC started to place a stronger focus on these home visits and to provide them within 72 hours in line with the postnatal protocol. UHWC received funding from October 2015- December 2016 to conduct postnatal home visits for their target population in Gaza city and North Gaza. UHWC became involved because of its experience with providing maternity services, and UHWC was interested to take this on due to female patients requesting for such home visits. Currently, MoH and NECC are still conducting home visits, but funding by UNICEF is only granted till November 2018. UNRWA also conducts home visits as part of their postnatal care service package for the refugee population in Gaza for a selected number of people. However, UNWRA is not part of the PNHV programme as it has its own funding source.

"We do home visits in antenatal and postnatal period. We have our own protocol according to WHO. We have to visit women in the antenatal period, if she is high risk AND does not come to the clinic for a certain reason. If we call her and she cannot come, defaulted with her last year, IVF and could not come, has many children, etc. Because we have an appointment

⁵³ MoH proposal 2012

system, we have to talk with the midwife, each week one midwife can come for a home visit. If the midwife cannot go, another midwife can go. She can take all the cases. For each clinic we have a certain bus, car for the home visit. I collect the number of home visits for each clinic at the end of the month.” – KII UNRWA

The third category of stakeholders are the midwives/nurses. From MoH a group of 30 midwives and nurses is trained on postnatal care skills and home-based child health care. All midwives working in the primary health care system of MOH in Gaza (10 at the time) were selected. This was complemented with the selection of an additional 20 nurses spread over different PHC clinics in Gaza. Selection was done with an eye geographic distribution and some of the nurses were already involved in home visits in the previous programs that stopped in 2004. The group of home visitors is dynamic as some of the professionals being trained stopped conducting home-visits and some others joined later. The professionals were trained at the beginning of the programme in 2011 and had a refreshment training of 2-3 days every year. The training includes Post-natal care; neonatal care; post-partum complications; behavioural change communication and early childhood development. Currently 25 trained professionals are still conducting home visits.⁵⁴

NECC and UHWC were responsible for their own trainings. Every year a small number (2-3) of their midwives and nurses joined the training as organised by MoH in collaboration with UNICEF. NECC has around 25 staff who are trained on postnatal care⁵⁵, UHWC trained 415 health workers on neonatal care services⁵⁶. It is not entirely clear how many of these conduct home visits.

4.1.7 Attention for national and local context in terms of culture, beliefs and gender issues

The PNHV programme in its design addresses the strongly held believe in Gaza that postnatal care is only important for babies and not for women. Within the PNHV attention is given to both, and therewith contributes to addressing this widely held notion. A stakeholder remarked:

“During postnatal care you will find that a mother comes to check baby and not to check herself, and we are not against her for checking her baby, but the idea that she should care for herself also. We think through evidence and field experiences & observation and many facts, it’s related to culture mentality of the society and from gender dynamic that we are sanctifying our children and serve them, but some times more than ourselves. We are not caring for ourselves from medical and social part” – KII Stakeholder

The PNHV programme also focusses on other cultural notions and believes, such as not wrapping new-born babies, putting salt on the umbilical cord, not taking a bath for the mother for around 40 days after deliveries, etc.

As mentioned in the Theory of Change, to enhance the chances for success, involvement of fathers in the Palestinian context is essential. The interviews made it clear that there is a strong notion that postnatal care concerns women and new-born only and not men. While during discussions in relation to the Theory of Change it became clear that stakeholders think it is important to address this notion, this has not yet been built into the design of the programme. Currently, no attempt is made to systematically try to involve the fathers of the new-borns during the home visits, and or address gender issues.

⁵⁴ Information from interviews with key informants

⁵⁵ NECC annual reports

⁵⁶ UHWC progress report 2

4.2 Efficiency findings section

The efficiency chapter aims to answer the following evaluation question: ***To what extent did UNICEF's work represent the best possible use of available resources (human, financial, other) to achieve results of the greatest possible value to recipients and the community?***

4.2.1 Cost-per visit

UNICEF provided the evaluation team with an overview of funding used by the PNHV programme but no detailed information of what type of costs were covered by the programme (such as all related staffing costs, monitoring costs, TA costs, etc.) from that budget. From that overview provided, it can be seen that the budget for the programme has increased steeply between 2012 and 2016. While the number of women visited on a yearly basis also increased over time, the costs per woman increased from US \$ 20,35 in 2012 to US \$ 36,44 in 2016. Thereby it has to be taken into account that this amount is not per visit made, as between 18 – 37 per cent of the women also received a 2nd visit, and between 6 – 21 per cent a third visit depending per year.

Year	US \$ for PNHV spent	Nr women visited	Cost per women visited
2012	\$65.029	3.195	\$20,35 (incl 34% 2nd visit, 18% 3rd visit)
2013	\$64.118	4.610	\$13,91 (incl 36% 2nd visit, 13% 3rd visit)
2014	\$ 83.171	4.544	\$18,30 (incl 18% 2nd visit, 6% 3rd visit)
2015	\$129.473	5.182	\$24,99 (incl 37% 2nd visit, 20% 3rd visit)
2016	\$273.420	7.503	\$36,44 (incl 35% 2nd visit, 21% 3rd visit)
Total	\$615.211	25.034	\$24,58

The team also reviewed budget spent according to Budget plans (Table 1 under The Post Natal Home Visiting programme description). Thereby it seems that the total amount provided to the three organizations together amounted to US \$ 856.783, or US \$ 241.572 more than indicated in the financial overview in the table above.

When comparing the budget plans the costs per woman reached are as follows:

Table 6 Budget allocated according to budget plans: total budget per year and organisation and possible costs in NIS per woman

Year	MoH Budget (NIS)	MoH women reached	NIS/woman	NECC Budget (NIS)	NECC women reached	NIS/woman	UHWC Budget (NIS)	UHWC women reached	NIS/woman
2011	155.050,00	N.A.	N.A.						
2012	244.373,20	3195	76,49						
2013	230.290,00	4610	49,95						
2014	217.524,00	4544	47,87						
2015	315.660,00	4570	69,07	222.863,16	1255	177,58			
2016	281.260,00	4860	57,87	752.888,94	1817	414,36	589.621,00	1255	469,82
Total	1.444.157,20	21779	66,31	975.752,10	3072	317,63	589.621,00	1255	469,82
Approx. USD	411.137,11		18,88	277.786,87		90,43	167.859,20		133,75

According to this table the budget received by NECC and UHWC are much higher than for MOH, with very different costs per woman visited. However, these are incomparable as there are huge differences in what components are covered by the budget. Due to the unavailability of financial reports, the budget cannot be disaggregated for the different program components.

However, also the qualitative data reveal that the budget was more tight for MOH than for others, especially NECC, which has its own organizational structure with staff, cars, systems, etc.

Everything was easier for NECC. When MOH people heard from the experiences of the NECC: they said they did not have the same resources and would sometimes fill in the form as if the resources were there. – notes from FGD's with health providers

MOH nurses indicated that their equipment is less advanced (e.g. they have to carry heavy equipment), there is lack of fuel, cars and time to provide the services.

A cost-effectiveness analysis from a large cluster randomized controlled trial for new-born home visits in the first week of life by community based surveillance volunteers in Ghana showed that for each mother-baby pair visited at least once, the cost of the intervention was \$33,70. The intervention costs a mean of \$10 343 per new-born life saved. The incremental cost-effectiveness ratios were \$379 per life-year saved at a rate of 20 deaths per 1000 livebirths and had a 99% probability of being highly cost-effective.⁵⁷

Due to the substantial health system costs and the shortage of health professionals in many LMIC's, WHO recommends that in some settings visits by Community Health Workers (CHW's) may be more feasible than visits by midwives, but requires careful programme planning and adequate resource allocation.⁵⁸ However, while this might be the cheaper option, the use of CHW's is not common in Gaza, while many midwives are unemployed. The WHO guidelines also indicate that the 'postnatal care may be complemented by additional mobile phone-based contacts between the health system and mothers'.⁵⁹

4.2.2 Implementation according to plan

The PNHV program consists of three components:

- i. training of midwives and community health workers on postnatal care skills and home-based child health
- ii. provision of postnatal home visit kits for midwives conducting the field visits
- iii. conducting home visits targeting high risk pregnant women and their new-borns

With regard of i) training; as an initial overall project proposal is not available, it is not possible to compare the number of trained providers (25 for MOH, 25 for NECC, 415 for UHWC as described in relevance chapter) to what was planned for. It is clear though that training has taken place, please see the effectiveness section for more information on that.

⁵⁷ Pitt, Catherine et al. "Cost and Cost-Effectiveness of New-born Home Visits: Findings from the Newhints Cluster-Randomised Controlled Trial in Rural Ghana." *The Lancet. Global Health* 4.1 (2016): e45–e56. PMC. Web. 11 Apr. 2018.

⁵⁸ WHO (2013). Recommendations on postnatal care for the mother and the new-born.

http://www.who.int/maternal_child_adolescent/documents/postnatal-care-recommendations/en/. Recommendation 3.

⁵⁹ WHO (2013). Recommendations on postnatal care for the mother and the new-born. Recommendation 2.

ii) Postnatal home visit kits were distributed, but the number is not reported. Nurses mainly at MoH indicated their PNHV-kits were empty by the end and no responsibility was taken to substitute the missing or defect resources.

For the iii) home visits conducted; NECC and UHWC exceeded the number of women planned to reach, while MOH exceeded in some years and underachieved in others. The number of women planned to visit and the number of women that were visited by MoH⁶⁰ are presented in the table below.

Table 7 MoH number of women visited per year (excluding NECC and UHWC)

Year	1 st visit (48-72 hours)		2 nd visit (1 week)		3 rd visit (6 weeks)		Total visits
	#Planned	#Visited	#Planned	#Visited	#Planned	#Visited	#Conducted
2011	1500	NA ⁶¹	1500	NA	1500	NA	4843 ⁶²
2012	3000	3195	3000	1098	3000	565	4858
2013	5000	4610	1000	1674	1000	614	6898
2014	3000	4544	? when needed	1271	? when needed	256	6071
2015	5000	4570	? when needed	1323	? when needed	188	6081
2016	5500	4860	? when needed	1037	? when needed	92	5989

UHWC planned home visits for 1000 women in their project cycle from October 2015 to December 2016⁶³

Table 8 UHWC number of women visited per project cycle

Project cycle	Total	1 st visit (48-72 hours)	2 nd visit (1 week)	3 rd visit (6 weeks)
	# Planned	#Visited	#Visited	#Visited
Oct 2015-Dec 2016	1000	1255	512	276

NECC had slightly different performing indicators. Instead of on the number of home visits, they report on the coverage of at least three postnatal sessions, whether at home or in the facility⁶⁴

Table 9 NECC number of women who receive at least 3 postnatal sessions in the 6 weeks postpartum

Women who receive at least 3 postnatal sessions in the 6 weeks postpartum		
Project cycle	# Planned	#Received
Feb 2015-Feb 2016	700	1255
April 2016-April 2017	1200	1817

⁶⁰ MOH workplans 2011-2016, compared to annual reports 2011-2015 (2016 not available; for 2016 monthly reports used)

⁶¹ NA = Not Available

⁶² Total number of visits, not disaggregated for first, second or third visit

⁶³ UHWC (2016) Final report

⁶⁴ NECC (2016 & 2017) final reports

They disaggregated the total number of sessions by place (home or facility), but did not do this for the total number of women.

4.2.3 Enabling and hampering factors for implementation

While in general the home visits were accepted by the mothers and their families, some women would refuse a home visit because of problems with the husband or the feeling that their house is inappropriate. In the beginning of the programme incentives were brought (donations in kind supported by other donors) which were very much appreciated, but this was stopped due to lack of funding. Some women referred to it.

“I wished if they would bring a bucket of pampers (diapers) as a gift.” – FGD visited women

Also midwives/nurses feel barriers to visit homes. In general they say to feel more safe and secure when they can conduct the home visit with two nurses.

MOH faced the most hampering factors, which were mainly the lack of transport, fuel and having to conduct home visits after their regular work in the office is finished. The lack of a proper registration system makes it difficult to identify cases and find the right homes or phone numbers. The war of 2014 made this even more complicated, when mothers had to be found in shelters or new replacements.

“Yes we tried our best to reach to the case during this difficult period especially if mother left to another house or moved with another family.” – KII key informant

However the number of home visits in 2014 did not go down.

People tend to ‘shop’ for services with different providers, because they know certain drugs will be out of stock in one place or they will get an extra ultrasound in the other place. This means many pregnant women are registered at more than 1 place and receive double services, also in postnatal care.

“I am from Rafah, sometimes I visited the women and found her have a visit by the NECC before me, there is a duplication in visits between me and the NECC's clinic. I don't know, they told me to report it.” – FGD health providers south & midzone

The lack of a centralized Health Information System makes it difficult to control this and coordination between the different providers about cases is absent.

4.2.4 Capacity and expertise in place

Generally, the distribution of health personnel per population in Gaza is reasonable with 22 doctors and 40 nurses per 10,000 population (UNFPA, 2016). However, specialty and subspecialty areas, including in midwifery and new-born care, are greatly under-represented. Out of the 40 nurses per 10,000, only 2 are midwives. Development of midwifery programs in the past years have increased the number of midwives from 130 in 2010 to around 400 in 2016. However many are unemployed. The PNHV programme used the available human resources within the system of MoH, NECC and UHWC; no new nurses were recruited for implementation of the program. However, many nurses/midwives from MoH have to do the home visits after their working hours in the clinic or the number of home visits to be conducted per nurse per day is perceived as too many.

"If you have one or two visits per the day, they will be as honey on your heart. While, if you have four or five first visits you go on your eyes (you hate to do them)." - FGD health providers Gaza, NECC.

Postnatal care is so far not only insufficiently addressed in the health care system, but also in the training curricula of health providers. This was managed by introducing trainings for nurses and midwives on postnatal care. The training focused on those meant to conduct the home visits, but missed the opportunity to strengthen the capacity of a broader pool of health providers working in MCH in order to integrate postnatal care more in their overall tasks and responsibilities. In fact, postnatal care, including home visits, should be part of the capacity of every midwife or nurse working in MCH. This could be done through continuous training and strengthening the postnatal care component in curricula of nursing and midwifery schools.

4.2.5 Coordination and collaboration

One of the main observations is that the PNHV programme seems a project with limited integration in the continuum of MCH care; from preconception and ANC at PHC level, to delivery at hospital level and back to PHC for postnatal and new-born care. Many of the postnatal care issues could be addressed throughout the continuum of care. For example counseling and involvement of the father/family start during ANC, but men are not allowed in many facilities and despite the high numbers of ANC visits, women do not get counseled on postnatal care issues other than the hand-out of brochures which are often not read.

It is a missed opportunity towards a more holistic approach on postnatal care. PNHV for high-risk cases is said to fill the gaps of the health system, but the gaps are too large and cannot be tackled without addressing immediate postnatal care at hospital level and postnatal care at clinic level as well. There are initiatives in the country, for example to improve immediate postnatal care in maternities, but some stakeholders consider that coordination with the UNICEF and all other partners should be strengthened. While there is coordination at the national level where UNICEF work plans are signed by government and key implementing partners, at health facility level people are not aware of such coordination.

"Unfortunately we heard about home visits program as strange people, and we didn't share in planning, or decision making." – KII Stakeholder at a delivery facility of MoH

The lack of coordination between the different levels of care is also reflected in the lack of communication. Information exchange between the care levels mainly relies on the responsibility of the woman. Based on the medical risk assessment a woman is informed during antenatal care whether she is a high-risk case and eligible for the PNHV programme. In case she is, the mother will need to inform her Primary Health Clinic or Provider directly after delivery in order to receive timely postnatal care at home. If the woman gets complications during labour and therefore becomes eligible for home visits she should inform PHC as well. If she is told to do so depends on counselling at the maternity facility.

"We heard like anyone who listens about this program, and we don't have any role in home visit program, we are providing postnatal care 4-6 hours when she stay in the hospital, but after finishing these 6 hours we don't have any relation with them, mother will go to primary health care, and they provide separate service that is different than what we provided in the hospital" – Key Informant

Previously PHC was informed by the maternity facilities through fax, but in practice this does not work due to time constraints in the facility. Medical information about the delivery is noted in the MCH Handbook, but during the visit the woman is rarely asked for the handbook or details about the delivery. Therefore the care to the woman seems quite straightforward and guided by a checklist rather than tailored to her specific situation. For example, the evaluation team noted that iron supplementation is standardly given, even when a woman received several units of blood in hospital and risks iron overload. Another example occurred during a home visit 8 days post caesarean. The sutures of a Pfannenstiel incision could easily be removed by then, but the hospital informed the woman to have them removed after 10 days, so she was instructed by the home visitor to go to the clinic for suture removal. By this, the whole advantage for a post-caesarean patient not having to travel to the clinic is diminished. These kind of examples could easily be overcome if there are clear protocols and communication or feedback lines with doctors. Protocols can also prevent false practices, such as the provision of antibiotics for episiotomy, or even normal labour, for which there is no evidence.

*‘Mostly, we advise the women who have Caesarean section or episiotomy to take Zinnat.’
‘We allow to any postnatal case, which we visited her and she has a pregnancy file in the clinic, to take Zinnat after labor.’ – FGD health providers Gaza and Gaza North*

Exchange between the different implementing partners did not systematically take place and the efforts for partnership strengthening and learning from best practices are minimal, although there is a window for that, as MoH is the regulator of all the services, and currently NECC is channeling funds for MoH.

4.2.6 UNICEF support, program improvement and use of result-based planning and management

Beside the financial support, UNICEF’s support consisted of capacity building of nurses and midwives and supervision during accompanying field visits, often followed by the monthly review and evaluation meetings. These meetings take place with staff from UNICEF and MOH, including nurses and midwives who conduct home visits. During the meeting challenges and successes are discussed. Gaps, such as in transportation or mobile telecommunication are addressed and acted upon. Apart from monthly statistical reports, there is no regular reporting of these meetings, so information about the content comes from interviews with stakeholders, who provide examples of improvements as a result of these meetings, such as in transportation or the provision of a mobile card with airtime.

“In the first month of the program we lost a mother. She was discharged from the hospital, with high BP and oedema. The midwife came to her home and advised the mother to go to hospital, but she did not obey and the mother died. From that time we implemented that in those cases ambulances have to be called and come immediately, while the midwife should not leave the woman alone.” – KII Stakeholder

The technical assistance is perceived quite well, while the inconsistency of the financial support causes a lot of insecurity.

"They told us that the program had been cancelled, and we should stop the visits. We went for the visits and we didn't know that the program had been cancelled. After that, they told us again that the program hadn't been cancelled and we have to work. Then they told us that the

program had been cancelled. They stopped it without any meeting and they didn't inform us. Now they ask us to go for the visits. There is no coordination.” – FGD health providers Gaza and Gaza North

Apart from the monthly review and evaluation meetings, there is no clear evidence on efforts to improve the program over time. The monitoring & evaluation of the program has challenges due to a number of reasons: there are no clear outcome indicators, annual reports include some outputs, but no outcomes and the reports do not provide an analysis which could be used for reflection and direction. It seems the annual reports are not used for review and program direction. Therefore result-based planning or management is insufficient.

4.3 Effectiveness findings section

The effectiveness chapter aims to answer the following evaluation question: ***Were the objectives of UNICEF's PNHV program achieved? (include unintended effects)*** It includes unintended affects and assessed to what extent the program has contributed to the following subheadings/themes.

4.3.1 Knowledge and skills of home visitors

One of the main activities of the PNHV program was training of nurses and midwives. They gained new insights, especially about nutrition, breastfeeding and hygiene practices but also early childhood development that was recently introduced. As can be seen from the quotes below, this was highly appreciated.

R2: the last lectures they started to teach us to educate the lady how to deal with her new-born as adult and talking to him as mature, during their growth their mothers should deal with them as a big persons.

R3: they told us about the new-born this information from the first day he can hear us [...]

R4: you can teach the baby the good habits from the first day of his life [...]

R: we learn how to deal with the new-born at the first 4 months of life to know his needs and how to manage his colic, these information are new knowledge we gained even if we are educated and specialized as midwives or nursing but we don't know it before.

R: we gained a new knowledge every work shop.

R: we didn't know before about the pregnant physical exercises, that they should do it during pregnancy and after delivery.

- FGD health care providers south & midzone

In general the providers feel they received sufficient training, but some would like to have more training workshops. Especially how to deal with psychological disorders is perceived as a gap.

Many midwives consider postnatal care as part of their job that they practice as well in the clinic, but feel that a proper job description is missing. Nurses feel that they can accomplish the tasks of the midwives because of their gained experiences and training, while others consider the home visits are unique for midwives only.

While health providers feel that their training is sufficient, qualitative data from interviews, FGD's and observations reveal a lot of variation in technical skills and commitment. Procedures are not followed consistently and some basic health checks are skipped and there are differences between MoH, NECC and UHWC.

'Concerning the mother's examination, the nurse examined the body temperature and the blood pressure during the home visit. While, she didn't examine the pulse, blood glucose level, the abdomen, the breast, nipples, and hands and legs. The nurse examined the caesarean scar for one woman only; moreover, she didn't examine the episiotomy for all women. It is worthy to mention that one woman, who the nurse didn't examine her caesarean scar, her wound got infected and she visited the clinic on the next day.' – Notes from FGD visited women south and midzone

This is also reflected in the time spent in the homes, variating from 10 minutes to several hours. Some women felt the home visitor was in a hurry and did not provide them with enough health education. The scope for improvement in counselling techniques is also recognized by the evaluation team. Health education is often provided as a lot of information giving, rather than real counselling which should be more of a conversation and giving guidance based on specific needs.

Even though the variation in services provided and time spent by the home visitor, the postnatal women valued the received visit highly. They appreciated the attitude of the home visitor, which was much more positive than the attitude perceived in clinics, the things they learned and the answers provided to their questions and insecurities.

'If the midwife didn't help me may be I would be lost' - Prime mother, visited by MOH-Gaza

4.3.2 Detection and referral of complications

The annual UNICEF reports provide some information about the women that were advised during the home visit to visit a health centre or hospital for check-up. However the information is inconsistent throughout the years and numerator and denominator are not always clear. Some reports use the denominator of 'women for whom the information is available', other just 'women'. While the text describes '[n] mothers out of [n] mothers were advised...', the number [n] used as denominator is often not the number of women visited, but the number of home visits (which is higher, because some mothers are visited 2 or 3 times). In some annual reports only a percentage is given (2011), while in others also crude numbers are provided. Based on the inconsistencies in denominators, percentages throughout the years cannot be compared and an analysis is difficult to make. Table 10 presents the information that is available from the annual reports. It shows the crude numbers of referral increase every year.

Table 10 Information from the program annual reports about case referral

	2011	2012	2013	2014	2015	2016
Number of home visits	4843	4858	6898	6071	6081	Annual report available (n.a.) not
Number of women visited	N.A.	3195	4610	4544	4577	
Women advised to visit Health Centre for check-up of themselves	[n] N.A. 9,7%	235	308	374	666	
Women advised to visit Hospital for check-up of themselves	N.A.	N.A.	N.A.	15	4	
Women advised to visit Health Centre for check-up for their children	67	88	169	114	205	

However the 'advise to go to the hospital or health centre' does not provide information about whether the woman followed-up the advice, the reason for referral, the outcome etc. Therefore nothing can be concluded about the effectiveness of the program on detection and referral of complications based on statistical evidence.

Qualitative data provide mainly single cases of timely detected complications. In general every provider and key-informant involved in the program is able to provide examples about cases that needed referral, such as late PPH, hypertension, sepsis (including as a result of a gauze left in the vagina), new-born breathing problems and jaundice. Many belief that this has saved lives. On the other side there are also examples of missed opportunities, like the woman who's wound was not checked and needed to be admitted for infection the next day. A case that was mentioned by several was that of a woman who refused to be referred and died as a result from hypertensive complications.

'I visited one case, and she died. At first, she was an aged woman, who didn't want to be pregnant, she prayed to God to die because she got pregnant. They detected the cause of

death that was pulmonary edema. While the home visit, her blood pressure was high. She skipped the medication doses, and I advised her to take the medication and to visit me in the next day quickly. She seemed to be careless about her life, and she didn't visit the clinic in the next day. I couldn't go back to her in the next days, because they would ask me about the reasons. Two days after the visit, she died. I told the doctors that we visited her and I intimidated her that she would have thrombosis if here blood pressure elevated more.' - FGD health providers Gaza and north-Gaza

According to Key Informants they learned from this case and decided that a midwife should stay with a patient that needs referral until the ambulance arrives.

4.3.3 Attention for psychological problems

Only the UNICEF annual reports of 2014 and 2015 report on the psychological status of the women during the home visit and, as with referral for complications, the denominator is not consistent. Furthermore the reports do not provide any information on action taken after diagnosis and provided support for mothers to cope.

Table 11 Information from the program annual reports about psychological problems

	2011	2012	2013	2014	2015	2016
Number of home visits	4843	4858	6898	6071	6081	Annual report not available (n.a.)
Number of women visited	N.A.	3195	4610	4544	4577	
Women reported psychological problems ('Stay sleep, Insomnia, Loss of appetite, Eating too much, Speak slowly, Feeling tired')	N.A.	N.A.	N.A.	355	245	

From the qualitative data it is found that the attention for psychological problems differ per health provider. While MOH nurses used the two questions in the program questionnaire for screening, NECC nurses standardly used the Edinburgh Postnatal Depression Scale. NECC and UHWC furthermore have the possibility to refer cases to a psychological therapist at the clinic, but at MOH there is no protocol available for the treatment of psychological problems after the delivery; the nurses provide emotional support themselves, ask the family to do so or refer her to the doctor. At UHWC a psychologist was sometimes coming along to the home visit. They also report to organize counselling/awareness sessions about psychological support in the clinics. Many nurses felt that addressing psychological issues is a gap in their training.

Many visited women feel psychologically supported by the home visit, they feel being precious and cared of and it raises their self-esteem. Even though the home visit itself is perceived as emotionally supportive, most women interviewed said they were not specifically assessed for or counselled on psychological problems after delivery.

4.3.4 Breastfeeding

All stakeholders (women, husbands, home visitors and key informants) mentioned the positive effect of the program on breastfeeding practices. Women felt encouraged to breastfeed and recognized benefits of breastfeeding that they did not see before. Especially prime-para benefited from instructions and tricks, for example in adjusting the position of the baby. But also multiparous women mentioned that they learned new things about breastfeeding which made EBF more successful for a

longer time than after previous pregnancies. Many women found out about the possibility to keep expressed milk in the refrigerator.

'I didn't know how to breastfeed, the visiting midwife taught me how to breastfeed and hold the baby, I breastfeed him in front of her. Unless the midwife, I wouldn't have known who to hold and breastfeed the baby. My family felt happy, I didn't breastfeed my previous children, they drunk an artificial milk.' - FGD visited women, Rafah

Home visitors were very pleased with the training they received on breastfeeding. They felt better equipped with knowledge and skills to make breastfeeding successful and referred to simple tricks such as using a syringe for an inverted nipple.

'We try to convince the ladies about the benefits of breast feeding and we teach them to use the syringe in order to treat the inverted nipple and the ladies were so happy about that and they came to the clinic to thank me for helping her.' – FGD health care providers south & midzone

Remarkable is that they feel they have to fight against wrong beliefs about the benefits of artificial milk, not only from the community but also from some doctors, who often prescribe artificial milk for the treatment of (physiological) jaundice.

'I am fighting using of the artificial milk. I convinced many women to prevent the artificial milk. I asked them to don't listen to the doctor advice and to throw the artificial milk container.' – FGD health care providers North-Gaza and Gaza

The time spent on breastfeeding counselling differed a lot per health provider, as appears from the qualitative data of women and home visitors and was also observed by the evaluation team during home visits. Some home visitors were very dedicated and would not leave until breastfeeding was successful, they would even come back the next day to follow-up. Others rushed independently if breastfeeding was successful.

Figure 8 shows the percentage of new-borns receiving exclusive breastfeeding at the timing of the home visit. According to the statistical reports from the home visiting program in 2012, 80.7 percent of the new-borns were receiving exclusive breastfeeding at the first home visit, this decreased for the second home visit (77.1%) and again for the third home visit (73.1%). A similar decrease by home visit can be seen in 2013. However, in 2014 the percentage of children receiving exclusive breastfeeding remains stable, over 80%, for each visit and in 2015 we can see an increase in children receiving exclusive breastfeeding from the first (77.5%) to the third visit (81.4%). It has to be noted that the EBF during the third visit is only based on the small number of women that received a third visit.

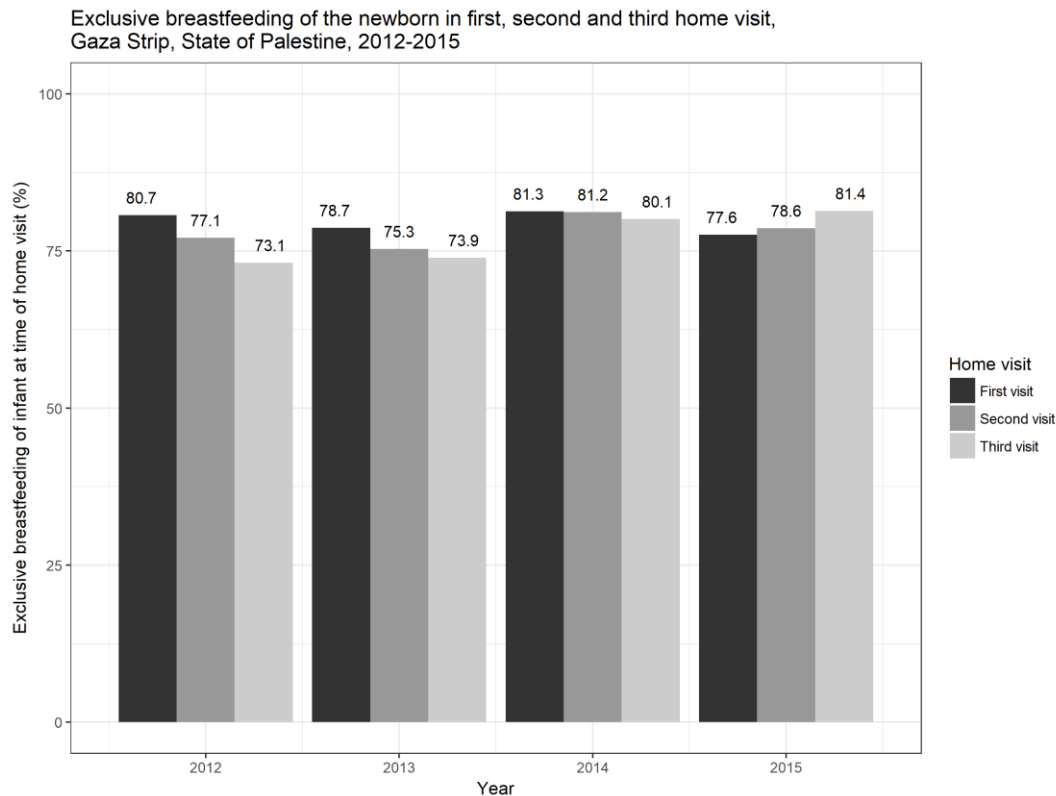


Figure 8 Exclusive breastfeeding during home visits by MoH

4.3.5 Awareness of family planning and birth spacing

From 2013 onwards the UNICEF annual reports started to report about the number of women that, according to the program questionnaire, wanted to use family planning. This was usually between 45%-50% of the women visited. IUD and pills have the highest preference. There is no information on whether the women actually started to use the contraceptives.

From the qualitative data it reveals that home visitors were indeed providing information about family planning and birth spacing, but the intensity, timing, audience and method for providing information about family planning differ. It seems cultural norms are stronger than the influence of the program. It is usually the husband or mother in law who decides whether a woman will take up family planning. Especially prime-para will not use family planning until they have got more children. Contraceptives are used rather for birth limiting once the desired amount of children is reached, than for birth spacing. There is a worry that the side effects of contraceptives will affect fertility. Also the sex of the baby is a determinant and many women tend not to use family planning before they have a baby boy.

Home visitor (HV): 'during a visit for a prime-gravida her mother, husband and mother in law were available at the visit. When I told her about family planning she discussed it with her mother in law, neglected her husband and asked her what is your opinion shall I go to do it?'

Facilitator (F): 'what was her response?'

HV: 'She refused. She said our women are not doing family planning.'

F: 'did you try to discuss it with her?'

R: 'yes, I tried my best with her, I said the lady is studying at the university and she needs a break between pregnancies. There are a lot of woman who get pregnant directly after the 40th day postnatal. But she refused and said "no, we are helping in raising them up". On the second

visit I found that her door was locked by her mother in law, I had to take the permission of the mother in law in order to do the visit and she should be there.'

– FGD health providers south and midzone

It must be clear that effect of the program on birth spacing and family planning is limited without the involvement of the husband or if a women lives in an extended family also her mother in law and by postnatal counselling only. Awareness raising should start earlier and be applied throughout the whole continuum of care. Like with counselling on other topics there is room for improvement in the counselling techniques. Another factor that might affect the prescription of contraceptives is the absence of written protocols for postnatal family planning. To the question when to insert an IUD post-caesarean answers from midwives differed from immediately to 6 months postnatal.

4.3.6 Traditional norms and practices

Due to the home visits nurses and midwives became more aware of the many traditional practices still present within families. It gave them the opportunity to counsel and change habits.

'Through this project I got to know a lot of different cultures, during our visits I saw many false traditions like using oil and salt for the umbilicus, some people use ink for it, we tried to change these bad habits for people and we noticed disappearance of this through the last year as a result of this project we increased people awareness.' – FGD health providers south and midzone

Beside oil and salt on the umbilicus and rest of the body home visitors found practices like putting starch on the baby's navel or twisting the navel by a hair of a horsetail, bathing the baby immediately after delivery, giving herbal teas to the baby to prevent flatulence, the use of crystalized sugar for the treatment of jaundice, tight wrapping of the baby, eye liner for the baby which can obstruct the lacrimal ducts and use of bitter substances for weaning off breastmilk. Also traditional beliefs for the mother, such as not to bath after the delivery to keep the milk hot, were encountered and discussed.

Many women that were visited said the counselling regarding traditional practices was new to them, but informative and changed their habits. Unlike the family planning they were less guided by the opinion of mothers (in law). Also some of these family members would listen to and accept the advices of the home visitors.

4.3.7 Physical exercises

Although one of the objectives of the program is to encourage mothers to do postnatal physical exercises, it seems that in most cases this does not go beyond the hand-out of brochures and advice to mobilize. Some of the nurses and women visited mentioned the Kegel's exercise being explained.

There is no protocol about the postnatal physical exercises and counselling is relatively new to the providers as well, so it might be that they do not feel empowered enough to give the right instructions.

'We didn't know before about the pregnant physical exercises, that they should do it during pregnancy and after delivery'– FGD health providers south & midzone

4.3.8 Role of the father

There seems to be a general belief in Gaza that men do not have a role in 'women's affairs'. 'It is not part of our culture' is often heard and in some MCH clinics the presence of men is even forbidden. Qualitative data show that men are not pro-actively involved by the home-visiting program. Whether

they are participating during the home-visit and to what extent it is desired varies among women, husbands and health providers. They are often not encouraged to be present, but allowed if they show interest by themselves. Some home visitors ask men to be out, because they feel embarrassed to ask certain questions.

'We feel embarrassed when the husband stays at the same room while we are doing the care or helping the mother in breastfeeding. If he is not shy from me I will not feel shy from him, so I learn his wife the breast feeding in front of him.' – FGD health providers South

However, other home visitors, especially in the north, reported that husbands encouraged the program and liked to participate during the visit by helping the nurse in her work and encouraging their wives to follow the nurse's advices. Additionally, the nurses noticed that the husbands care about the mother and the child issues; they shared the babies' care with their wives.

While some husbands are not interested to be present or receive detailed information, others felt benefit from their involvement in the home visit and noticed that they feel valued and increased motivation to support their wives and children.

Husband (H): 'My wife told the midwife that her husband helps her in everything.'

Facilitator (F): 'How did you feel about that?'

H: 'That encouraged me to take care of my kids more and more and these things calm my wife down and the kids love me more and more. My daughter related to me so much.'

F: How do you feel with the fathers who don't share their wives to take care of their kids?'

H: 'That's so bad, every father should share his wife of take care of his kids. Because every kid needs the love of his/her dad.' – husband midzone

The same variation can be found with women. Some women said they would not encourage the presence of their husband, but many also said that they feel emotionally supported when their husband is involved in care.

'Yes, I like that. I feel he supports me emotionally and feels what I feel.' [...] 'He was always asking me if I need something he was holding the baby and makes her a milk bottle if I am tired or asleep, and also he was changing her clothes.' – FGD visited women in Khan Younis

Facilitator: Who did go with you to the clinic?

R1: 'We went Alone.'

F: 'Did you like your husband to join you to the clinic?'

R1: 'I wish that.'

R2: 'When he came with me, I felt a great psychological support.'

F: 'Do you like your husband to be during a visit?'

R3: 'Yes, for sure, not all the men are educated.'

R4: 'He may be busy or he may just refuse to stay.'

R5: 'She should talk to the husband about the mood and psychological condition during period days and after delivery, they should increase their awareness about these issues.'

- FGD unvisited women midzone

The qualitative information shows that, even while people tend to think that men should not or do not like to be involved, the reality is often different and there should be room to tailor to the situation. Out of respect to both the woman and her husband, the presence of the husband should at least be

allowed and proposed as an option during care in the clinic and at home. Health providers should be encouraged and empowered to promote this and get improved competencies in involving the fathers.

4.3.9 Responsive parenting and Early Childhood Development

As described under 'knowledge and skills of home visitors' ECD was only recently introduced in the training and the program. An effect is not noticed yet. So far parents did not receive much information on the interactions with their babies.

4.3.10 Postnatal Care and immunization follow-up

The annual reports do not provide information about follow-up for postnatal care in the clinic. Due to the absence of a proper registration system it is not known whether women who are advised to go for their 2nd and 3rd visit to the clinic follow that advice. The high coverage for vaccination indicates vaccination attendance is fully embedded in the general population and does not need a lot of extra encouragement.

Many women in interviews and focus group discussions said that they were encouraged by the home visitor to go for a clinic visit. It seems that due to the postnatal home visit women and their families are more aware of the importance of postnatal care.

'It is good that midwife came to our home to examine my wife's surgical stitches. But still it was not enough. I think it should be clinic visits for 4 times during one year after delivery. Additionally, it should be obligatory appointments like vaccination appointments for baby.' - Husband midzone

However, while many women go or want to go, there are still remaining barriers like transport, care for other children, crowdedness in facilities, bad attitude of staff in facilities, lack of privacy and absence of drugs.

'When nurses treated me badly, I felt like I wanted to go out the clinic and wouldn't go back again. I felt like they told me to go to private clinic.' – Woman visited by MOH, Khanyounis

These barriers show that one cannot expect an effect on postnatal follow-up in the clinics if the postnatal facility care is not strengthened.

4.3.11 Program reach

While the efficiency section describes the number of homes reached compared to what was planned, this section will show program coverage and aims to answer the question to what extent the program reached the right homes.

Figure 9 shows coverage of the program per year and compares this to the total registered births.⁶⁵ Between 2011 and 2014 only MoH conducted the home visit, within this time frame the number of women visited by the home program has increased from 2012 to 2013 but remained stable after that. However, in 2015 and 2016 a bump in the coverage can be seen as NECC and UHWC respectively joined in the initiative. The same can be said for the coverage of the program as percentage of total

⁶⁵ Data on registered births in Gaza Strip from 2005 to 2015 were derived from the Palestinian Central Bureau of Statistics (PCBS) website (retrieved March 2018, from: <http://www.pcbs.gov.ps/default.aspx>). Data on women visited by the UNICEF home visiting program were retrieved from the statistical reports from the home visiting program and were available for the years 2012 to 2015, as the 2011 report did not provide information on the number of women visited and the 2016 report is incomplete.

live births. Where in 2012 5.4 percent of live births has received a home visit in Gaza Strip, this increased to 8.1 percent in 2013, to 9.5 percent in 2015 and 12.9 percent in 2016⁶⁶.

The percentage of women who received a follow-up visit by the program slightly decreased over time during the time period where only MoH was active (2011-2014). In 2012 34.4 percent of the women who received a first home visit received a follow-up home visit as compared to 28.0 percent in 2014. A decline was also seen in the percentage of women receiving a third home visit, which decreased from 17.7 percent in 2012 to 5.6 percent in 2014. In 2015 and 2016 an increase in the proportion of 2nd and 3rd follow up visits as a result of the inclusion of NECC and UHWC, as compared to 2014.

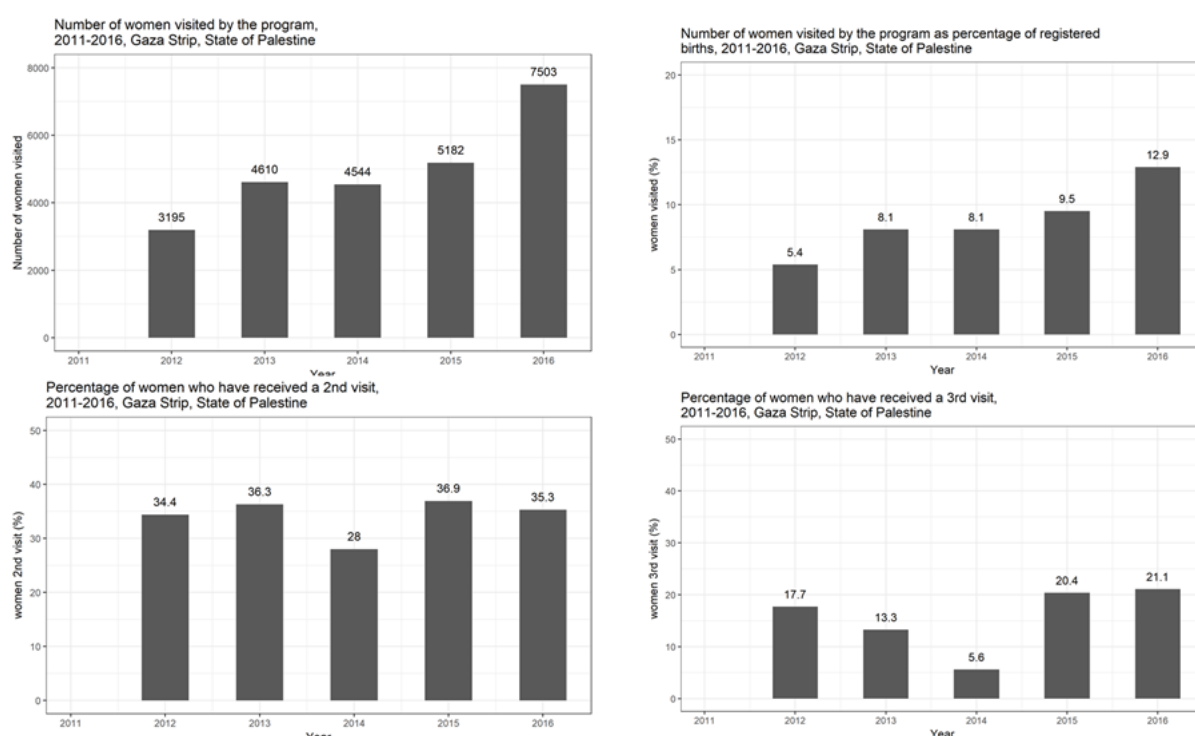


Figure 9 Coverage of the PNHV programme

In order to get an idea of to what extent these 8% coverage in 2014 reached the right homes a reanalysis of MICS data was done and compared to data of the program, for medical risk factors.

As part of the MICS, women who had a live birth 2 years preceding the survey were asked questions related to care, health and complications during that last pregnancy, delivery and the postnatal period. Based on what was available in the MICS and on the high-risk criteria defined by the program (see relevance chapter), a selection was made of women who potentially could have been targeted by the home visiting program and to compare these to the women who actually received a home visit. Table 12 shows the risk factors that were analysed and the proportion of women that the risk factor applies to in the MICS and in the PNHV program.

As part of the MICS, women who had a live birth 2 years preceding the survey were asked questions related to care, health and complications during that last pregnancy, delivery and the postnatal period.

⁶⁶ Note: the number of registered births does not take into account twin or multiple pregnancies and therefore the coverage of women having received a home visit might be underestimated.

Table 4 Risk factors during pregnancy and delivery for women with a live birth within 2 years of the survey (MICS) and the women in the PNHV program

Variable		MICS 2010		MICS 2014		PNHV 2011	PNHV 2014
		% of total	% of risk pregnancies	% of total	% of risk pregnancies	% of total	% of total
>=2 perinatal deaths	Yes	0,9%	0,80%	0,5%	0,7%	(missing)	(missing) -
	No	99,1%	99,20%	99,5%	99,3%	-	-
Age <16 or > 40	Yes	3,5%	7,7%	2,0%	3,6%	(missing)	(missing) -
	No	96,2%	91,8%	98,0%	96,4%	-	-
	Missing	0,4%	0,5%	-	-	-	-
Anaemia	Yes	5,9%	13,0%	13,1%	23,7%	36,3%	39,0%
	No	94,1%	86,9%	86,5%	76,0%	-	-
	Missing	0,0%	0,1%	0,4%	0,2%	-	-
Bleeding during pregnancy	Yes	2,8%	6,2%	5,6%	10,1%	3,0%	3,0%
	No	97,2%	93,7%	94,0%	89,6%	-	-
	Missing	0,0%	0,1%	0,4%	0,3%	-	-
Bleeding during or after delivery	Yes	3,3%	7,3%	6,1%	11,0%	22,7%	20,3%
	No	96,7%	92,6%	93,9%	89,0%	-	-
	Missing	0,0%	0,1%	0,0%	0,0%	-	-
Hypertension	Yes	11,0%	24,2%	13,0%	23,6%	12,1%	20,0%
	No	89,0%	75,7%	86,5%	76,1%	-	-
	Missing	0,0%	0,1%	0,4%	0,3%	-	-
Multiparity	Yes	17,4%	38,4%	11,6%	21,0%	16,6%	(missing) -
	No	82,6%	61,6%	88,4%	79,0%	-	-
	Missing	0,1%	-	0,1%	-	-	-
Multiple pregnancy	Yes	2,3%	5,1%	1,9%	3,5%	(missing)	(missing) -
	No	97,6%	94,9%	98,1%	96,5%	-	-
	Missing	0,1%	-	-	-	-	-
Prime gravida	Yes	14,3%	31,5%	20,9%	37,8%	40,9%	44,6%
	No	85,7%	68,5%	79,1%	62,2%	-	-
	Missing	0,1%	-	-	-	-	-
Any risk factor	Yes	45,3%	-	55,3%	-	-	-
	No	54,7%	-	44,7%	-	-	-
Caesarean section ^b		14,10%	19,10%	17,50%	20,80%	34,50%	28,30%
Total^a		1.878	849	1.336	739		

a. Weighted number of observations. b describes latest delivery and is not considered a risk factor by PNHV

Most frequently occurring risk factors in the total population and among the total number of risk pregnancies were prime gravida (first childbirth), hypertension and multi parity (having had six or more deliveries). In 2014 the contribution of anaemia as a risk factor increased.

If we compare the occurrence of a risk factor among women in the population to the risk-factors that were targeted by the program, we can see the program has proportionally targeted more women with risk factors of anaemia, bleeding during or after delivery and prime gravida. Also caesarean section

cases are relatively more often visited (see table 11 above). Remarkable is that hypertension was proportionally less present as a risk factor in the program than in the general population, although much better presented in 2014 than in 2010. We can also see that the percentage of home-visited women who had a caesarean section decreases whereas nationally, this proportion increases (Figure 10). These discrepancies might indicate that certain risk factors are more often reason for a home visit than others or that some risk factors are overlooked when referring patients to the program. From the qualitative data collection it seemed that some home visitors practiced some selection bias, not following the eligibility criteria. Some women were visited although they are not aware about having any risks, some women who live far away (and might need the visit the most) were skipped, as is illustrated by the quote below:

R: 'they tell me to go and do the home visit, I decide not to go for those who are living far away, at country area.'

F: 'did you inform them [the facility management] that you will not go to these area?'

R: 'no, the home visiting program is an arrangement between me and the ladies, I don't tell my supervisors even if I tell them about the distance they will order me to go.'

– nurse in FGD health providers south.

According to the MICS data in table 11 a total of 45.3% (2010) to 55.3% (2014) of the women had any of the listed risk factors or were prime-gravida during their last pregnancy, and this does not even include all risk factors (such as previous caesarean section or diabetes). This proportion is far higher than the current coverage of the home visiting program (8.1% of all registered births in 2014) and it will be a huge challenge to reach this.

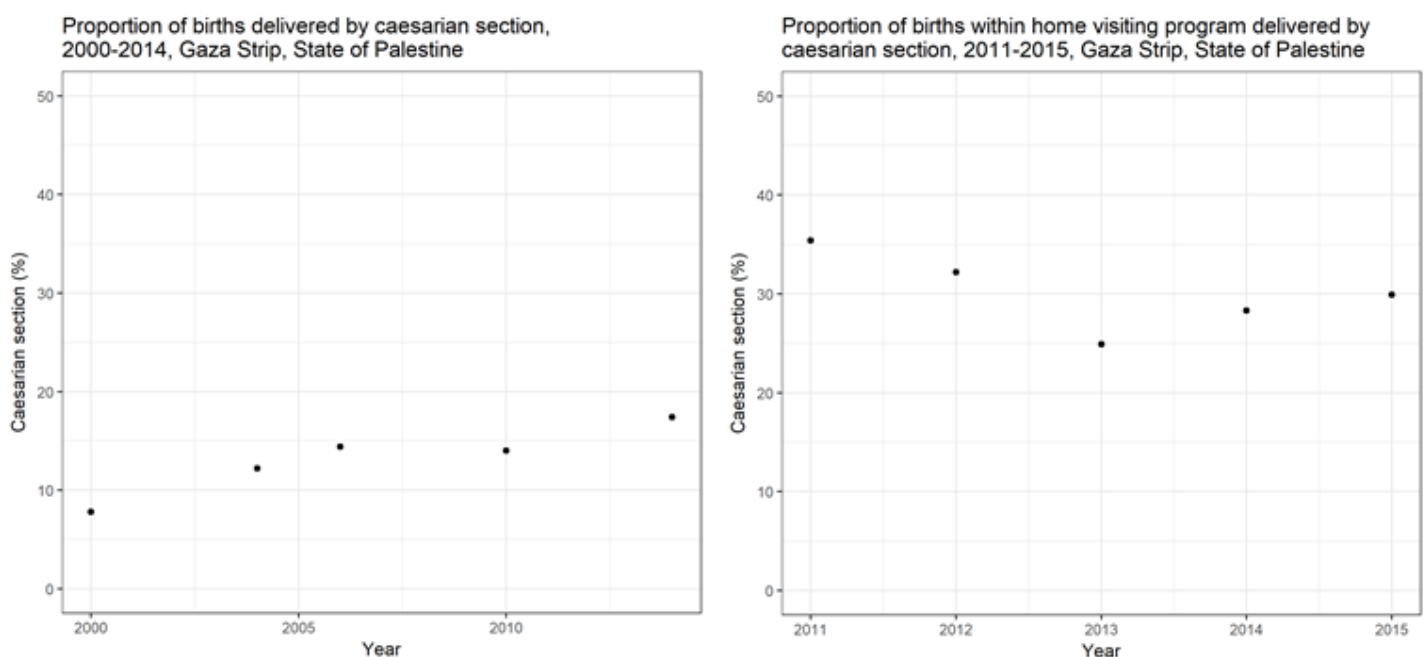


Figure 10 Births delivered by caesarean in Gaza and in the programme

4.3.12 Equity and Gender equality

When we compare women who deliver in the general population (MICS) to women in the PNHV program for age and education level in 2011 and 2014 (table 12), we can see that women who completed secondary school are relatively visited more often and that women with minimal education

are left behind. This seems to be the case in other years as well (with the lowest education group not exceeding 0.8% in annual reports).

Table 5 Characteristics of women who had a live births 2 years prior to the survey (MICS) and women visited by the PNHV

	MICS 2010		MICS 2014		Years of education	PHNV 2011	PHNV 2014
	% of total	% of high risk	% of total	% of high risk		% of high risk	% of high risk
Elementary/Primary	5,70%	7,00%	2,90%	3,60%	0-3y	-	0,60%
Preparatory	18,30%	21,40%	13,90%	16,8%	4-8y	-	12,20%
Secondary	46,70%	45,90%	47,10%	45,1%	9-12y	-	64,60%
Higher	28,60%	24,70%	35,70%	34,00%	>12y	-	22,60%
Missing	0,70%	1,00%	0,40%	1%			
Age 15-19	3,80%	6,20%	6,20%	9,40%		15,50%	17,10%
Age 20-24	24,70%	24,90%	32,30%	32,50%		34,60%	35,30%
Age 25-29	30,30%	19,90%	29,60%	23%		19,70%	20,60%
Age 30-34	23,30%	18,80%	18,10%	16,90%		16,20%	16,10%
Age 35-39	12,50%	19,40%	10,20%	12,20%		10,30%	5,20%
Age 40-44	4,80%	9,60%	3,40%	5,90%		3,70%	5,70%
Age 45-49	0,50%	1,20%	0,20%	0,40%		-	-
Age 50-54	0,10%	0,10%	-	-		-	-
Sex ratio	0,99	0,98	1,21	1,23		-	1,24
Caesarean section	14,10%	19,10%	17,50%	20,80%		34,50%	28,30%

Women under 25 are relatively visited more often, which probably has to do with many prime-para being visited. Women aged 35-39 are proportionally underrepresented among the women who received a visit.

Unfortunately this quantitative analysis cannot be done for other social determinants, such as socio-economic status or rural/urban living area due to lack of program data. We can however show coverage of the program per governorate and see how this relates to the overall existing gaps in PNC

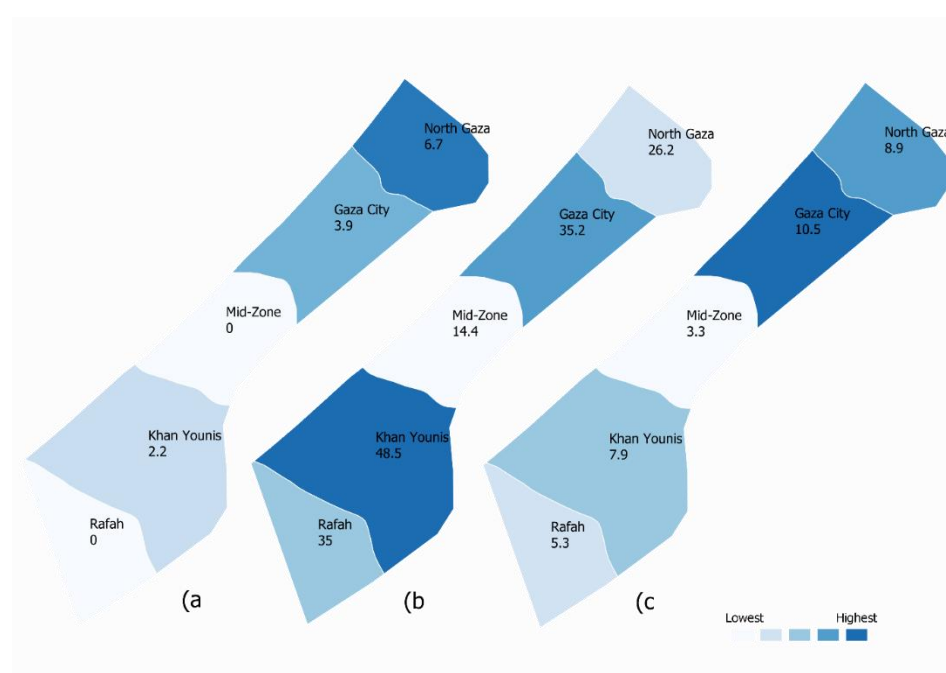


Figure 11
No PNC for new-borns (a), no PNC for mothers (b) and coverage of home visiting program (c) in 2014, Gaza Strip, State of Palestine.

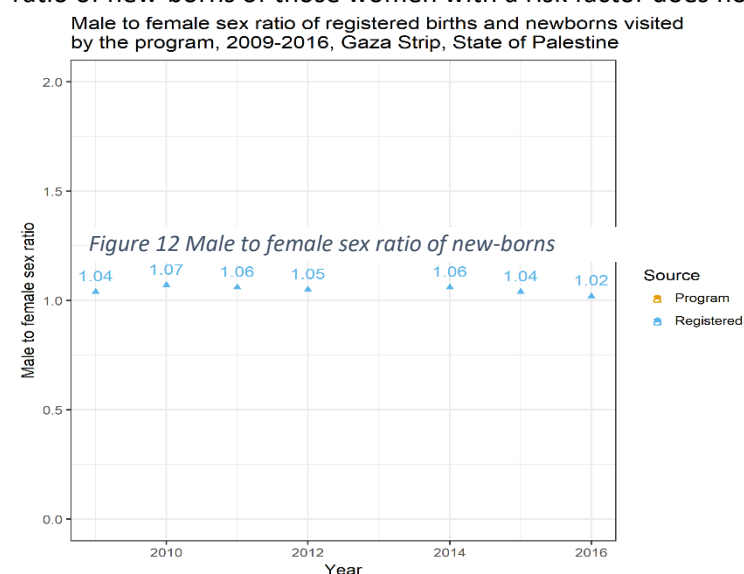
coverage for new-borns and mothers, according to the MICS 2014. In figure 11 it is shown that the percentages of new-borns who do not receive a postnatal health check is quite low and lower in the south than in the north (11a). It must be mentioned that these postnatal health checks for new-borns are linked to the BCG vaccination and is not per se a full quality health-check. For the mothers (11b) midzone also has the lowest number of women who missed a postnatal health check (14.4%), while in Khan Younis this is 48.5%. Figure 11c shows the percentage of women who have been visited by the home visiting program as a percentage of registered births in that governorate. It shows that the proportion of women receiving a home visit is lower in the south than in the north, which equals the pattern of need for postnatal checks for new-borns, but conflicts with the high needs for mothers in the south.

As mentioned before under program reach, qualitative data show that women in rural areas risk to be left behind. Some midwives and nurses avoid to visit cases in border or rural areas because of fear for sexual harassment or dangerous animals, like dogs. Also transport is an issue and ambulances cannot easily reach houses in rural areas due to road conditions.

'The driver may blame us if his car is damaged. He may say why you don't apologize to the woman or go to nearest home or he may let us walk all the distance between the main street and the ladies house. If the road is okay for the ambulance he drives until I reach the ladies house but if it is not good he waits for me on the main street.' - FGD health providers South

Only the home visits of UHWC particularly targeted cases in hard to reach and dangerous areas in Gaza North. Being a grass root organization set up in an area of marginalized people, this is in line with UHWC's mission to care for those who are hard to reach. Because staff is from the same area and know the area, they feel secure to visit these.

Women who are visited by the PNHV program more often have a male child than a female child (sex ratio 1.2), whereas the sex ratio of all registered births in Gaza Strip is around 1. The sex ratio of new-borns from all women in the MICS who had a birth in the 2 years preceding the survey and the sex ratio of new-borns of those women with a risk factor does not differ⁶⁷. This indicates that there is no



⁶⁷ Data on registered births come from the bureau of statistics. The ratio is based on number of female and male births. Please note that the MICS data covers a different cohort (live births within 2 years preceding survey) than the PBS does (all births within calendar year) and are therefore not comparable. However, the data does show that the sex ratio among new-borns of MICS mothers did not differ between high-risk pregnancies and all pregnancies, and therefore we would expect to see no difference in sex ratio between the registered births and the women who were visited.

reason to believe that women with a risk factor more often deliver a new-born boy or girl. The higher prevalence of male babies in the program might mean that women and their families, who have to report to the clinic once they delivered to receive a home visit, do this more often when a male child is born than when a female child is born. Qualitative data also show that there is a gender preference for boys.

Apart from the sex of the child the program data provide no characteristics of the new-born to inform about the focus on vulnerable children or children with disabilities. While congenital anomalies is one of the leading causes of neonatal mortality in Gaza, nothing is mentioned about this in the program documents or annual reports. Under respondents of the qualitative data collection no women with children with congenital disabilities or disabilities for themselves were identified.

Visiting staff of the PNHV program is all female, which is logically explained by the fact that currently in Gaza people would find it culturally inappropriate if a male provider visits a young mother in her home. Female home visitors however face gender discrimination which is further described under unintended consequences.

4.3.13 Unintended consequences

A consequence of the program that was not part of one of the objectives, but clearly came out of the qualitative data is that the program in many cases increased mutual understanding and respect between health providers and women. Health providers mention that the home visits make them more kind and sensitive and increases their relation with people.

'we learned to become humble and more humanitarian with people from the home visit; we have a kind relationship with them as a result to that.'

'this is the most important things that we learned from the visit due to that we had a kind relation with the people.'

'I can put myself in her place.'

'Yes they told us their very specific problems that they can't tell anyone else.'

'I stayed there for 2 hours until she knew how to breastfeed.'

- FGD health providers South

As written before, women also felt valued by the home visiting program and in general appreciated the attitude of the providers. This increases the trust in the health care system and might motivate them to make better use of health care (although not proven). At the same time due to lack of continuity women can get frustrated again.

Some of the nurses complained that women would continue calling them with questions.

'My problem is they keep giving me a missed call and I had to recall them. Even after 2 months, to ask me about the vaccine, they referred to me in everything, people still call me for advices and counselling related to their health.' - FGD health providers South

When people feel trusted with a certain health care provider they want to rely on this person and, in the absence of a strong health care system on postnatal care, they do not know where else to go with their questions. A helpline could be a solution, but while this was implemented as part of the program (according to key informants, no program documentation has confirmed this), it is not known or

widespread. None of the respondents in the qualitative data mentioned it and the nurses did not refer to it.

The fact that, especially in MOH, midwives/nurses have to do the visits after working hours and sometimes have to pay for their own taxi's or airtime.

"It is not only you who suffer from this problem, transportation is the problem for all of us, I take private car on my own, I paid more than 70 to 100 NIS for transportation this month." – FGD health providers South & Midzone

Some of the women visited expressed their dissatisfaction with the home visits being unannounced, they would prefer to receive a phone call in advance to announce the visit. The following quote from health providers shows how the lack of coordination make that a mother is at the clinic while the nurse is at her home, but also contains another great concern, which is that home visitors feel vulnerable to sexual harassments.

R: 'I want to add something: hopefully you will do it to us, we don't want to go alone for the home visit, at least to be with two nurses is better.'

R: 'yes we agree with her.'

R: 'Especially in the second visit when we went to do it, we found the husband alone at home and the mother was at the clinic for the baby's vaccine, we felt embarrassed, and sometimes we find men sitting in front of their house, so it is better to be two nurses not one for the home visit.'

R: 'that's right.'

R: 'our colleague in Gaza was harassed during the visit, and only God saved her, so it is better to be two nurses together doing the same visit.'

- FGD health providers

MOH does not have the capacity to send two nurses at a field trip, while at the same time many nurses and midwives in Gaza are unemployed. The concern of sexual harassment is not addressed by the project.

Major achievements and key successes

From the information outlined in this chapter some major achievements and key successes can be identified, being mainly the high satisfaction rate of women, the appreciation of training by nurses and midwives and the positive effect on breastfeeding and harmful traditional practices. Additionally health providers and key informants proudly mention many individual key successes of cases where they saved lives or timely detected complications for referral.

"I summarize the whole project. how can that happen by: the woman gets benefit from the service I provide and I get benefit from her experience, despite that I am a midwife that is not working at the antenatal sector so at the home visit I saw many things that happened to the lady that provided me a new experience from many parts: scientific, cultural, what do woman think that we can change, the home visits are so important, unfortunately people don't know about it regardless how much we talk about or inform, unless they have the visit and see what we do for them then they appreciate it and knew that if we don't visited them they will suffer from many things."

- FGD health providers south & midzone

The satisfaction rate of women about the program was also measured at the end of each visit. Although the UNICEF annual reports left this information out, it can be found in the monthly reports of all years. These patient satisfaction surveys show very high (often 100%) scores on satisfaction of the programme and service received, encouragement of the program, timing of the visit and benefit of the counselling. While the scores of 100% seem unrealistic and doubt the accurateness of the method, the high rate satisfaction is reinforced by the qualitative data.

A key success of NECC is that they were able to provide the services to all women registered in their clinics. This high coverage can be attributed to the fact that NECC is involved with home visits for a longer period of time, appreciates postnatal care as an integral part of their MCH services and is better resourced.

4.4 Sustainability findings section

The sustainability chapter aims to answer the following evaluation question: ***Are positive results from UNICEF's PNHV program likely to be sustained?***

4.4.1 Addressing sustainability in program design and implementation

As mentioned in the relevance section, the PNHV programme was a reintroduction of a home visiting programme and was able to make use of previous experiences with home-visits. In addition, the PNHV programme works foremost with MoH midwives and nurses that were already part of the primary health care system. The programme in its design did thus build upon existing institutional and local capacities.

The reconstructed Theory of Change mentions that the PNHV programme in its design and implementation was meant to work – amongst others - towards strengthening of the continuum of care around maternal and new-born health. Strategies thereby included training of midwives and nurses, increasing attention for postnatal care within midwifery and nursing curricula and policies, and monthly monitoring and review meetings. During the interviews with midwives, nurses and other stakeholders there was clear evidence that training around postnatal care has taken place. Respondents also mentioned that the capacity built as result of this training, will remain among those trained. Different respondents mentioned that commitment towards home visits has been built among midwives/nurses, but without further funding for especially transport, this commitment could not be translated into action.

However, this built up capacity and commitment towards home visits applies to the small pool of midwives and nurses involved in the programme only. As noted previously in the report (under efficiency), the PNHV programme being a standalone project lacking a more holistic approach towards postnatal care, missed the opportunity to make postnatal care a more sustainable component of the continuum of care. If the program stops now, home visits will stop and it is not considered likely that more women will return to clinics to receive postnatal care. For that postnatal care in the clinics should simultaneously be addressed and health providers in general should have strengthened capacities and be more aware of the importance of postnatal care.

In recent years, the number of midwives in Gaza has increased significantly because of a four year direct postgraduate training in midwifery having been put into place. For this new cadre, as well as for the two year training existing midwives, new job descriptions have been developed in 2018. These job descriptions pay considerable attention to postnatal care and the job description for PHC midwives also talks about home visits. However, there has not been a direct link between these developments and the PNHV programme.

An exit strategy has not been foreseen in the design of the programme. UNICEF thereby argued that the uncertain funding for the PNHV project implementation hindered addressing sustainability issues and an exit strategy. This as funding is provided on an ad-hoc basis through the humanitarian funding pool mainly.

4.4.2 Capacity and resources for scale up

In spite of capacity built among midwives/nurses, and the capacity that continues to be built through the midwifery post graduate programme, the home visit component is unlikely to continue, let alone scale up, without additional external funds. Different stakeholders, including from the Ministry of Health, indicated that there are no plans and no funds to support home visiting programmes. They indicate that the focus is more on strengthening postnatal care within the clinics as resources for

health are scarce and through clinic based care more women can be reached with PNC. A few stakeholders provided suggestions on how that could possibly be done.

“All women come back to the postnatal care, through immunization system. We can have the immunization schedule at 3 days, because then we will pick up the cases more early than when they come after 10 days. We should minimize the time where problems can occur. I think it is possible, they should be able to come to the clinic. I think it will be more sustainable if it happens like that. I think we need to redesign the program. We reach 10% of the cases, what happens to the other 90%? I think we can send a message after a 3 days that people come to the clinic.” – KII Stakeholder

The political and economic situation in Gaza strongly affects the sustainability of the programme. The closed borders severely impacts job and economic opportunities and therewith possible recovery schemes.

“This program is effective, but we can’t continue like that, due to shortage of everything. Ministry of health suffered from shortage in important supplies like renal dialysis, and heart catheterization, we can’t do screening and we don’t have basic treatment for people in Gaza”.
– KII Government Stakeholder

Many of the respondents, both women having been visited at home, as well as home visitors made remarks about the need to have better access to information and or counselling in the post-natal care period through social media. Even though many still do not have smart phones or internet at home, there are many who do have this. Quite a few respondents said to be looking at internet sites to find information on how to best care for their new-borns and or babies, and the need to receive guidance in relation to this. Capitalizing on these existing social media resources to enhance post-natal care through e-Health, would facilitate reaching out to many.

4.4.3 Systems and regulations at national level for follow-up of high risk cases

There are several committees in place that address different aspects of postnatal care such as the National Child Health Committee and the Maternal Mortality Committee which are part of the Reproductive Health Committee. These committee have not been put in place as result of the PNHV programme but provide opportunities to discuss different aspects of postnatal care including in relation to the PNHV programme. These committees are also supported by UNICEF. The Neonatal Mortality Committee also has a plan for early childhood development.

The Child Health Committee is a relatively new committee and chaired by the Deputy Minister. In this committee issues around infant and under five mortality are discussed. Within this committee it has been realized that it is best to focus on the early neonatal period. The committee of which UNICEF Gaza is a member has a plan to look at Early Essential Neonatal Care in collaboration with the Gaza Neonatal health network.

The Maternal Mortality Committee, which exists for many years, reviews every maternal mortality case. The committee recently worked on clarifying the criteria for maternal mortality to ensure that pregnant women who die for instance from traffic accidents or war (as happened in 2014) are not classified as maternal death. The Reproductive Health Committee is a new committee which looks at reproductive health in a more holistic perspective, including on pre-conception care, collaboration between different departments, hospitals and NGOs, and capacity building of human resources.

The PNHV programme set up monthly review and evaluation meetings with midwives/nurses and MoH and UNICEF. However, it is unlikely that these meetings would continue without further additional funding for the home visiting programme.

4.4.4 Ownership and program activities integration in stakeholders plans

NECC has plans to continue with postnatal home visits, like they have done for many years, but without donor support will not be able to implement the whole home visiting package. UHWC which does not receive any UNICEF funding currently, continued working on raising awareness around post-natal care, and incidentally undertake home visits for some critical cases. They are also trying to raise funds to be able to continue their home visiting programme.

While government stakeholders see the need for a postnatal home visiting programme, they also think that within the resource limited setting this is not feasible. Postnatal care within a clinical setting has a higher level of ownership. MoH plans to focus on strengthening postnatal care within clinics to have wider coverage. UNFPA has plans to support postnatal care but more around creating demand for clinic based care. WHO is also working on supporting clinic based postnatal care.

4.4.5 Allocated budgets for ongoing program activities

The current budgeting system in Gaza is more a survival mechanism and it is unpredictable what will happen. In most recent years, funding for health from Ramallah has been substantially reduced from i.e. 12 million in 2016, to 5 million in 2017 out of the needed 40 million US\$. While the health system used to be primary health care oriented, a stronger focus has in recent years been placed on secondary health care and securing funding for hospitals. While postnatal care has been mentioned in the plans, there are no government resources set aside for this.

The Ministry of health has plans to enhance sustainability but has not yet developed any written plans on how to achieve this. There are also challenges in relation to the work of the reproductive health committee, the maternal mortality committee, and the neonatal mortality committee, in terms of having resources available to fund steps that need to be undertaken.

No budget has been allocated for postnatal home visits. There is more interest in seeking resources for clinic based care.

“But the question is: Are home visit the right approach? It needs additional resources and who will fund it? We need to concentrate on other things that need resources like chronic disease. There is a poor funding situation, so we are caring for other high need topics in reproductive health, so it’s not sustainable to provide resources for home visits, it will be burning resources”
– KII Stakeholder

Within UNWRA, where the priority focus is also on strengthening postnatal clinical care, there are no sufficient financial or human resources to conduct home visits.

Key successes in terms of avoiding maternal and neonatal mortality are not really documented. The annual reports include mostly figures without much further interpretation. There are no case studies written up on the basis of the end of day reports produced by home visitors.

There are efforts though to analyse data, including postnatal care data, to put the issue more on the agenda. This is done by UNICEF and WHO together with the MoH.

4.5 IMPACT findings section

The impact chapter aims to answer the following evaluation question ***What has been the impact of UNICEF's PNHV program on mothers, health workers, families/ communities and others?***

As expressed by the evaluation team since submission of the proposal, undertaking an impact assessment without the existence of baseline data and in the absence of control sites and therewith a counterfactual, is actually not feasible. In addition, a survey for primary quantitative data collection would have to be extremely large to be able to detect statistically significant changes in maternal and neonatal mortality in a relatively small population like Gaza with low numbers of crude mortality rate. The team therefore suggested to reanalyse large scale existing databases such as the Health Annual Reports Palestine of MOH, the MICS of 2010 and 2014 and program data to describe trends over time. Statistical data are complemented by qualitative data that report on impact.

4.5.1 Neonatal morbidity and mortality

Most PNHV providers and key-informants belief there is an impact on the neonatal morbidity and mortality, which is also endorsed by international evidence. Home visits in the first week after birth are strongly recommended by the WHO to improve new-born outcomes, based on moderate quality evidence. Palestinian statistics however are not able to reinforce these beliefs and international evidence. The annual program reports lack indicators for neonatal mortality and morbidity. Secondary data analysis from MICS data is not able to show an effect of the recent initiatives on neonatal mortality, with a rate that seems to have stagnated between 2005-2009 (11.4 per 1,000 live births) and 2010-2014 (11.5 per 1,000 live births).

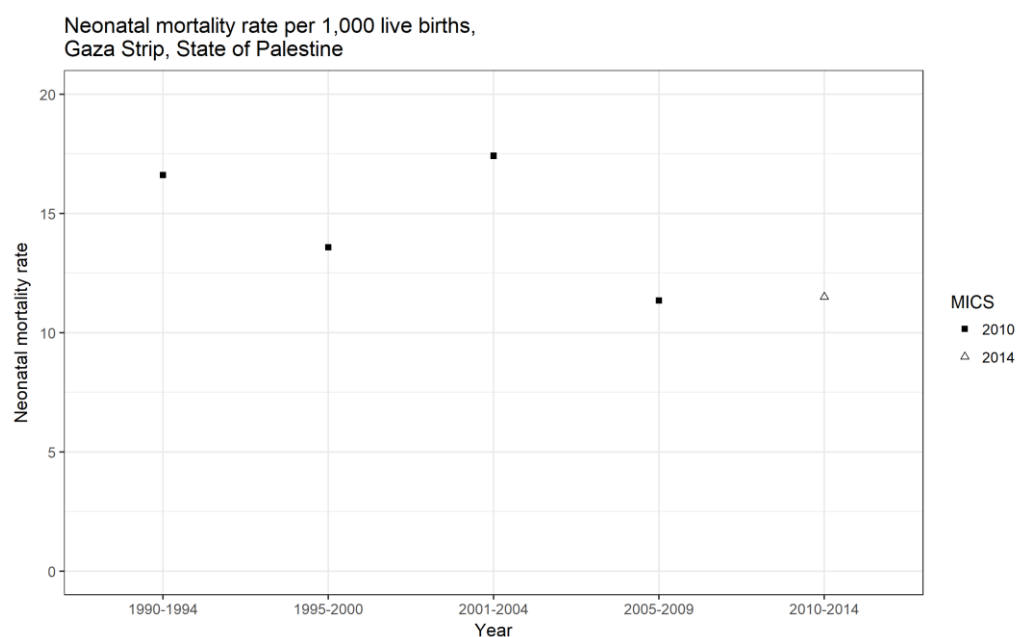


Figure 13 Neonatal mortality Rate

While there is an absence of quantitative evidence, qualitative evidence provides many examples of cases that might have contributed to decreased neonatal morbidity and mortality. Both women and health providers report cases that they belief would have been detected too late, were it not for the PNHV program. These include many cases of jaundice, poor drinking and dehydration, hypothermia, hypospadias, not passing stool and/or imperforated anus and singular cases of congenital heart disease and foreign body in the baby's airway.

4.5.2 Maternal mortality and morbidity

Similar to the neonatal outcomes, program annual reports do not include outcome indicators on maternal mortality and morbidity (such as anaemia or sepsis). Secondary analysis of data on maternal mortality rates (MMR)⁶⁸, show that maternal mortality has been going up and down with an overall decrease in mortality since 2011 (Figure 14). However, due to the lack of a program baseline or control site this decrease cannot prove to be attributed to the program. The increase in 2014 can be explained as a result of the war (16 maternal cases died as a result of violence).

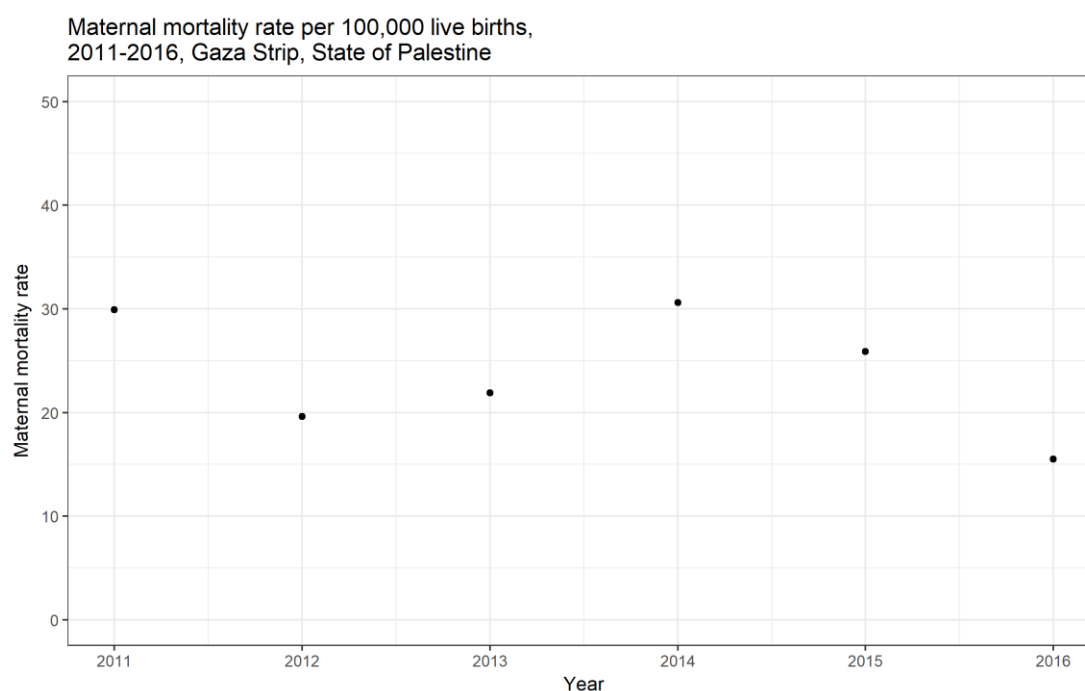


Figure 14 Maternal Mortality Rate

While there is an absence of quantitative evidence, qualitative evidence provides many examples of cases that might have contributed to decreased maternal morbidity and mortality. These include detection of late PPH, hypertension and sepsis by the health providers during the home visits.

‘We have different success stories. We visited a case with haemorrhage may be 2-3 days ago, nurse checked mother and she found that her blood pressure is low, so she cared about this point, and she transferred mother to the hospital, she took 3 blood units and she protected her from death.’ – KII NECC

One case that is mentioned by several is the death of a woman within the program that was detected with severe hypertension and referred to the hospital, but refused to go.

4.5.3 Breastfeeding

The impact on breastfeeding is believed by many to be the main success story of the program. Secondary quantitative analysis of MICS data shows an increase in Exclusive Breast Feeding (EBF) in children under 6 months from 14.5 percent in 2000 to 36.4 percent in 2014 (Figure 15). While this

⁶⁸ From the Health Annual Reports (MoH) as published on a yearly basis by the PCBS.

increasing trend started before introduction of the program, it is remarkable that a steep increase can be seen between 2010 and 2014, after introduction of the program.

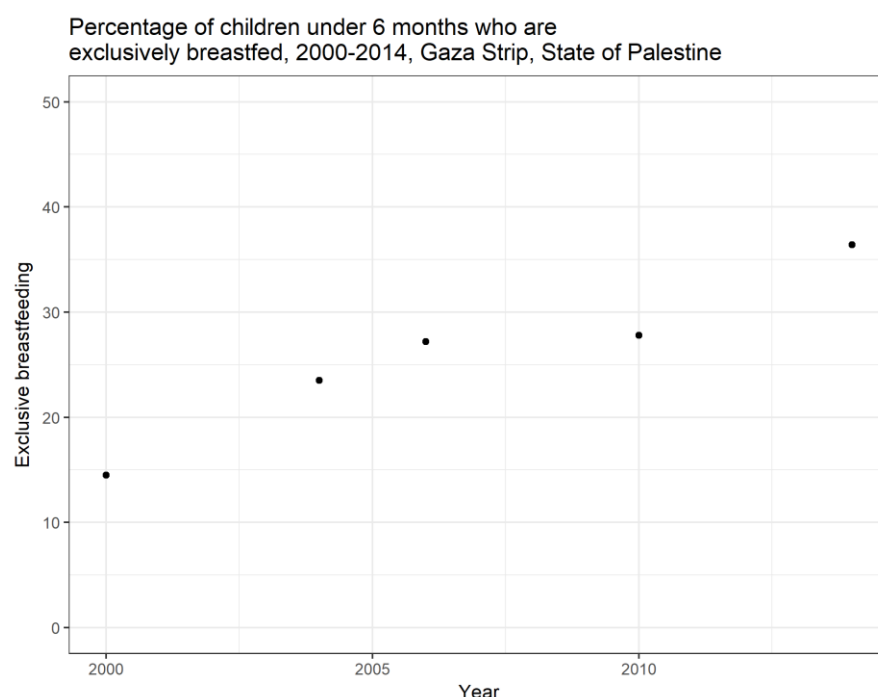


Figure 15 Exclusive breastfeeding in children under 6 months

The exact difference (Table 6) is 8.6% and is statistically significant ($p\text{-value} < 0.001$).

Table 6 Exclusive breastfeeding of children under 6 months, Gaza Strip, State of Palestine

	MICS 2010	MICS 2014	Difference	95%CI
Exclusive breastfeeding	27,80%	36,40%	8,6%*	(1,7% - 15,6%)
Total children 0-5 months	398	356		

*p-value < 0.05. 1. Based on MICS data from 2010 and 2014

While it is difficult to prove attribution, it is possible that the program has been a trigger for this steep increase in EBF. Not only because of high rates of EBF in the direct target population, but also due to spill-over effect of positive experiences to the community.

4.5.4 Family planning

Contraceptive prevalence rate increased between 2000 and 2014 with a little over 40% of married women aged 15-49 years using any modern form of contraceptives (Figure 16). Unlike as with breastfeeding, there cannot be seen a change in ongoing trend at the time of introduction of the program.

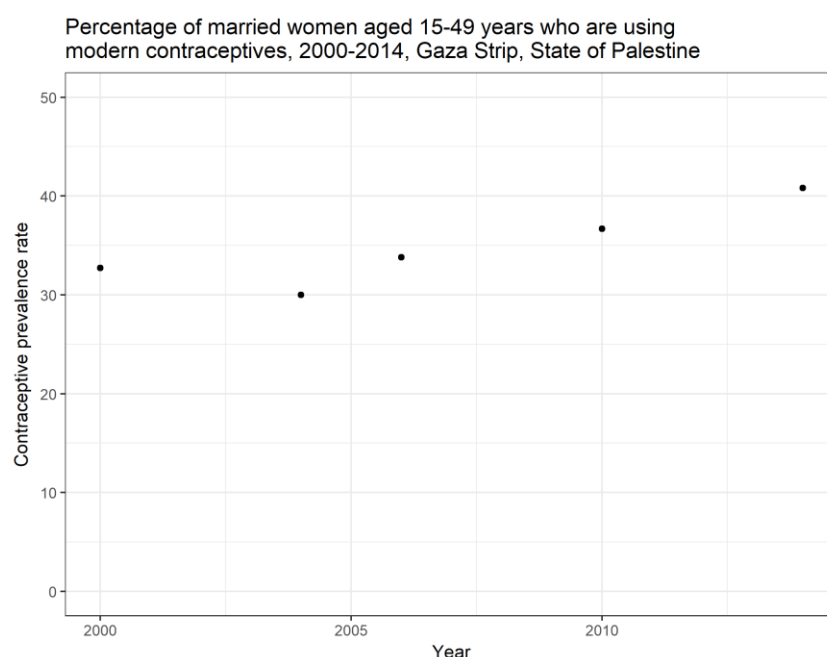


Figure 16 Contraceptive prevalence rate

Furthermore, according to the 2010 and 2014 MICS, the unmet need for contraceptives decreased from 17.0% to 10.7%, respectively (Table 7). The unmet need is defined by the MICS as the percentage of fecund and currently married women who are not using contraceptives but would like to either postpone (birth spacing) their next pregnancy or stop having children (birth limiting)⁶⁹. The unmet need of contraceptives is higher for women wanting to postpone their next pregnancy (11.2% in 2010 and 6.6% in 2014) than for women wanting to stop having children (5.8% in 2010 and 4.1% in 2014). The decline in unmet need between the 2010 and 2014 estimates is statistically significant for both birth spacing and birth limiting, meaning that in 2014 less women were not satisfied in their contraceptive need than in 2010.

Table 7 Unmet need for contraception among married women aged 15-49 years, Gaza Strip, State of Palestine ¹

	MICS 2010	MICS 2014	Difference	95%CI
Unmet need	17,00%	10,70%	6,3%***	(5,2% - 7,4%)
For birth spacing	11,20%	6,60%	4,6%***	(3,7% - 5,5%)
For birth limiting	5,80%	4,10%	1,7%***	(1,0% - 2,4%)
Total married women	6704	7959		

*** p-value <0.001. 1. Based on MICS data from 2010 and 2014

4.5.5 Immunization coverage

Palestine, including Gaza, has been known for a high immunization coverage (90-100%) over many years. Therefore the PNHV program has no additional impact on immunization coverage.

⁶⁹ Palestinian Central Bureau of Statistics, 2015. Palestinian Multiple Indicator Cluster Survey 2014, Final Report, Ramallah, Palestine

5 Conclusions and Lessons learned

In line with international evidence, **this evaluation shows that strengthening postnatal care in Gaza is highly relevant to accelerate the slowly decreasing maternal and neonatal mortality and morbidity.** Strengthening PNC can cover some of the current gaps in MCH and connects to national strategies that focus on primary health care, families and communities. In 2011 UNICEF chose to address these needs through the re-implementation of Post Natal Home Visits. Due to constraints in financial and human resources it was realized that PNHV could not cover all households and therefore not achieve universal health coverage; instead it was chosen to focus on those most vulnerable, namely women with high-risk pregnancies/deliveries and prime-para.

Postnatal home visits in the first week of life are strongly recommended by the WHO to improve maternal and new-born outcomes, based on moderate quality evidence. The PNHV in Gaza were highly valued by women and their families, it made them feel reassured and realize how important this care is. **Until now, many people in State of Palestine do not consider PNC as an essential component of MCH care and they tend to visit the clinic only one week post-delivery to receive the BCG vaccination and a health check for the new-born.** In addition, the home visits overcome several barriers to attend postnatal care in the clinic, being: postnatal physical constraints to travel; distance to the clinic, transport money or obligations at home; over crowdedness, lack of quality and privacy in the clinic.

While the PNHV programme serves a real need of high risk pregnancy/prime-para women, at the same time it becomes apparent that programmes efficiency faces some challenges, mainly in coordination and due to the absence of a holistic comprehensive postnatal care approach, and that without external continued funding the intervention cannot be maintained at the same level. Due to the absence of detailed financial reports it was impossible to calculate cost-effectiveness.

The lack of a baseline and/or counterfactual, as well as a strong M&E system, made it hard to give statistical evidence to effects and impact of the program. Effectiveness is mainly shown through qualitative data, while for impact it is impossible to attribute changes over time to the program. However, **some key successes** of the program in terms of effectiveness can be identified. These are a **very high satisfaction rate with women**, who feel precious and get increased self-esteem, great appreciation of nurses and midwives to their training, addressing harmful traditional norms and practices, and positive effects on breastfeeding practices. Nearly all stakeholders in the evaluation mentioned the **impressive effect on breastfeeding and midwives are recognized as strong agents of change** towards practices around this. Exclusive breastfeeding is also the only impact indicator which made a steep increase over time since introduction of the program. As said, it is difficult to prove attribution, but not impossible that the program has been a trigger for this steep increase in EBF. Not only because of high rates of EBF in the direct target population, but also due to spill-over effect of positive experiences to the community. In addition, the **home visiting programmes assisted with addressing and changing traditional beliefs and practices, as well as increasing mutual understanding and respect between health providers and women.**

Despite these key successes that were clearly identified by the evaluation, for other effectiveness and impact indicators evidence was less clear. **Earlier detection and referral of complications seem to happen, but cannot be underpinned with statistical evidence at outcome level** and there is no

straight impact seen on maternal and neonatal mortality. While stakeholders are able to mention many examples of cases detected and referred, at the same time there is **variation in the technical skills and commitment of home visitors**, resulting in cases being missed. Also other objectives of the home visits, such as attention for **psychological problems**, instructions on **physical exercises**, awareness for **family planning** and **birth spacing** and **attention for responsive parenting, including an active role of the father**, have insufficiently shown to have an effect.

While the programme has an **equity approach** to cover all geographical areas of Gaza and focus on those who are medically most vulnerable, home visitors seem to not always follow the eligibility criteria and regularly skip homes that are in rural areas or near the border. When analysing the coverage of the programme per governorate compared to postnatal care in the general population, it is seen there are **more home visits north than south**, which responds to the higher need for postnatal coverage for new-borns in the north, but conflicts with the higher needs for mothers in the south. In addition **no criteria are developed for inclusion based on social risks**, e.g. economic status, distance to facility, literacy rate or (social) problems at home, **while women with the lowest education profile are left behind.**

The sustainability of the programme lies mainly in the training of midwives/nurses, but **without external continued funding the other program activities are not likely to sustain and an exit strategy is not foreseen.** The **postnatal home visiting programme is quite a stand-alone project** which has limited to no interference with other pillars of postnatal care. While all stakeholders interviewed agree that strengthening postnatal care is very much needed, the strategic direction for this differs. The **majority of stakeholders believe in strengthening of the clinical component in order to be able to reach out to many more women in a resource constraint setting, and reduce the number of visits to those who cannot come to the clinic.** For this to happen though, more **awareness raising about the need of PNC for women themselves would be highly needed.** In addition, arrangements within clinics would also need to be made so that women would not have to wait a long time for their turn, and staff capacitated. Furthermore, use of an telephone based advisory services to which women, their partners and families can ask advice in the first days after delivery, could be explored. This as many women interviewed indicated to be using internet, or that others in their surroundings are doing so.

Programme weaknesses

Based on the evaluation results and analysis against the reconstructed Theory of Change, the following weaknesses of the programme can be identified:

- Due to the project starting as a humanitarian response, a brief project proposal was said to have been developed at the onset of the programme. However, this could not be shared with the evaluation team, nor could a clear programme description be shared. **Better documentation and or storage of key programme documents would need advisable.**
- **A systematic monitoring system and use of programme data for result-based planning was not in place.** While quite comprehensive data was collected on each case visited, this data was only partially digitised on an external computer of a consultant without appropriate back up. This resulted in data being lost.
- **Lack of detailed financial reports** indicating the costs of the different programme components;
- **Lack of a holistic approach to postnatal care at different levels:** immediate PNC in hospital, PNC in the clinic and PNC at home; and lack in extending capacities to a wider pool of health

providers, making postnatal care (including care at home when needed) an integral part of the capacity of every midwife or nurse working in MCH; this includes the lack of engagement in nursing or midwifery curricula;

- **Lack of a centralized Health Information System**, which keeps people ‘shopping’ for double services, hampers the exchange of information between different levels of care and complicates the collection of programme data;
- **Lack of a tracking system** to contact women who missed their appointment (in case of MoH) or which facilitates the pro-active targeting of those in special need of the services;
- **Lack of coordination and communication between different levels of care;**
- **Lack of an updated disseminated protocol for postnatal care**, leading to wrong non-evidence based practices, such as the use of antibiotics for episiotomy, iron supplementation on top of blood transfusion, delayed removal of sutures and the use of artificial milk to treat jaundice (by doctors, not by providers in the PNHV programme);
- **No specific strategy to engage fathers and extended families**, nor in the clinics, nor at home;
- **Regular lack of money for transport, fuel and airtime; no maintenance or substitution of broken/missing equipment**
- **Lack of ownerships for home visits at MoH**
- **Absence of an exit strategy**

Lessons learned

There are many lessons learned during this evaluation, among key learnings are:

- In the first place, the home visits facilitated a more **personalized approach** and allowed looking into problems that women had with breastfeeding or harmful traditional practices. The personalized practical support was very much valued and said to have been **helpful for continued exclusive breastfeeding, counteracting harmful traditional practices but also for improving self-esteem of the women visited**. Building in personalized approaches into other reproductive health services, would seem to be worthwhile. This could also be further pursued through the **further development of the helpline** which is part of the PNHV programme but underdeveloped and not wide spread.
- An unintended consequence of the program that was not part of one of the objectives was that the **programme in many cases increased mutual understanding and respect between health providers and women**. Health providers mention that the home visits make them more kind and sensitive and increases their relation with people. This means that service providers who start to understand the reality of the persons they serve better, will also be able to enhance their relationship with their clients, an important lesson to enhance services through better relationship building.
- The home visits contributed to the **realization that women themselves also need post-natal care** and not only their infants. While some headway has been made in this thinking, this would need a much stronger focus and would warrant awareness raising activities.

- Conducting home visits after finishing primary tasks of nurses and midwives (MoH) is not feasible; the NGO's start their home visits in the morning and divide the different tasks, including home visits, among the available nurses in the clinic. **When postnatal care is perceived as an equal component of the work, home visits can be done every moment of the day. Home visitors do not feel comfortable to conduct a visit alone and fear sexual harassment when they are out in the field.** In order to address these learning points, home visits to specific cases should be made part and parcel of routine jobs and also ensure safety procedures towards those conducting the visits.

6 Recommendations

Following the gaps identified and lessons learned through this evaluation, the evaluation team created pointers for recommendation to strengthen postnatal care. These pointers were validated, further developed and prioritized by the Evaluation Steering Committee in Gaza during a participatory exercise in May 2018. The following recommendations are the outcome of that exercise:

UNICEF to work towards enhancing better integration of post natal care into Mother and Child Health services, whereby postnatal care for both mother and new-born are seen as an equal component of their MCH care. This should include acceptable appropriate quality PNC in the clinic and home visits where possible and needed. In line with the WHO recommendations this care may be complemented by additional mobile phone- or web-based contacts. In line with the National Health Strategy 2017-2022, UNICEF could work with the MoH and other stakeholders to create linkages with the Family Medicine approach.

UNICEF to work towards enhancing the quality of post natal care through amongst others

- Working with MoH and other key players on the revision, standardization and implementation of the PNC protocols** and making these widely available and used in practice and training. Important thereby to address are amongst others: involvement of husbands; specific attention for those extra vulnerable and those socially at risk; maternal mental health, early child hood development, physical exercises and family planning.
- Working with other key stakeholders on the harmonization of services.** Integration of PNC in Family Health Care teams could be an important entry point for that and foster further contact between service providers and patients and reduce in the shopping of services.
- Supporting and lobbying (together with i.e. WHO) for a centralized Health Information System and improving programme documentation**
- Better coordination among providers** UNICEF and the MoH to identify and engage with partners that complement each other on the different components of the holistic PNC approach, including in hospitals, clinics and training curricula.
- Improving the capacity building structure around PNC**

Resource list

- ✓ Center for Theory of Change. CHD program documents and the GAC Results Chair.
<http://www.theoryofchange.org/what-is-theory-of-change/> CHD program documents and the GAC Results chain
- ✓ Health Cluster. Gaza Strip Joint Health Sector Assessment Report, September 2014
<https://reliefweb.int/report/occupied-palestinian-territory/gaza-strip-joint-health-sector-assessment-report-september>
- ✓ Miftah, Independent Commission for Human Rights, & United Nations Fund for Population Activities. *Country Assessment towards Monitoring and Reporting Sexual and Reproductive Health and Rights in Palestine*, (Palestine, 2015).
- ✓ MoH/UNRWA Overview of the Mother and Child Hand Book in Palestine.
<https://www.unrwa.org/resources/reports/overview-mother-and-child-health-handbook-palestine>
- ✓ MoH PNHV programme workplans 2011; 2012; 2013, 2014, 2015 & 2016
- ✓ MOH annual reports 2011-2015 (in Arabic)
- ✓ NECC Program progress report NECC Part 2; Reporting period from 17/2/2015 to 16/2/2016
- ✓ NECC Program progress report NECC Part 2; Reporting period from 10/4/2016 to 31/10/2016,
- ✓ NECC Final Report. Promoting PNHV and Enhancing the Nutrition and Health Strength of Vulnerable Children, 0 – 6 years at the NECC's well-baby clinics in Gaza, 10/04/2016 – 09/04/2017 final reports
- ✓ Palestine National Authority/MoH. Health Annual Report Palestine 2011
- ✓ Palestine National Authority/MoH. Health Annual Report Palestine 2014
- ✓ Palestine National Authority/MoH. Health Annual Report Palestine 2015
- ✓ UHWC Promoting Post Natal Health Care Services for Mothers and New-born in the Northern Area of Gaza Strip, implemented by Union of Health Work Committees and in Partnership with UNICEF, funded by Global Affairs Canada, From 15 – 10 – 2015 til 31-12-2016
- ✓ UNICEF Annex C; Programme Document, PCA 2017 NECC
- ✓ UNICEF Palestinian Family Survey; Monitoring the Situation of Children and Women, Final Report. 2010
- ✓ UNICEF Palestinian Multiple Indicator Cluster Survey 2015, Monitoring the Situation of Children and Women. Final report December 2015
- ✓ UNICEF PNHV Statistical (monthly) reports – 2011
- ✓ UNICEF/MoH PNHV statistical (monthly) reports – 2012
- ✓ UNICEF/MoH PNHV statistical (monthly) reports – 2013
- ✓ UNICEF/MoH PNHV statistical (monthly) reports – 2014
- ✓ UNICEF/MoH PNHV statistical (monthly) reports – 2015
- ✓ UNICEF/MoH Post Natal Care, Statistical Report Home Visits Programme, Annual Report 2011
- ✓ UNICEF/MoH Post Natal Care, Statistical Report Home Visits Programme, Mid Year Report 2012
- ✓ UNICEF/MoH Post Natal Care, Statistical Report Home Visits Programme, January – December 2012
- ✓ UNICEF/MoH Post Natal Care, Statistical Report Home Visits Programme, 1/9 2013 Report
- ✓ UNICEF/MoH Post Natal Care, Statistical Report Home Visits Programme, Annual report 2013
- ✓ UNICEF/MoH Post Natal Care, Statistical Report Home Visits Programme, Semi-Annual Report 2014
- ✓ UNICEF/MoH Post Natal Care, Statistical Report Home Visits Programme, Annual report 2014
- ✓ UNICEF/MoH Post Natal Care, Statistical Report Home Visits Programme, Semi-Annual Report 2015
- ✓ UNICEF/MoH Post Natal Care, Statistical Report Home Visits Programme, Annual report 2015
- ✓ UNICEF/MoH Post Natal Care, Statistical Report Home Visits Programme, April – August 2016
- ✓ UNICEF Post Natal Home Visiting Programme in Gaza Strip, Final Report, March 2014 (submitted to Iceland)
- ✓ UNICEF Situation Analysis of Children Living in the State of Palestine, 2016
- ✓ UNICEF SoP Strategy Note, Country Programme 2018 - 2022
- ✓ United Nations Fund for Population Activities, Victims in Shadows: Gaza Post Crisis Reproductive Health Assessment. UNFPA in partnership with WHO and The Palestinian Ministry of Health, 2014, (2015).
- ✓ WHO (2013) recommendations on postnatal care of the mother and new-born.
http://www.who.int/maternal_child_adolescent/documents/postnatal-care-recommendations/en/

Annex 1 Terms of Reference

UNICEF State of Palestine

Evaluation of a postnatal home visiting and neonatal health care services for neonates, infants and their mothers

Summary

Purpose	Evaluate the impact of the PNHV Services in Gaza on neonates, infants and their families, prepare recommendations for programme expansion including clear arguments for further health system reform. Evaluation of neonatal health core services in West Bank and Goza depends on available funding and it will be commissioned in the
Audience	Primary: UNICEF, MOH, NECC, PHCs, Secondary: Health professionals, families with neonates and infants, donors
Location	State of Palestine (West Bank and Gaza)
Duration	First Phase: 16 weeks for PNHV services Second phase (pending available resources): 11 weeks for Neonate services 27 weeks in total
Start Date	October 2017
Reporting to	Chief of Health and Nutrition, UNICEF SOP
Budget Code/PBA No	SC149901 & RR
Project and activity codes	4.2.10 Conduct external evaluation of PNHV and NN Health core services

Part one – External

I. BACKGROUND

Since the beginning of 2011, UNICEF State of Palestine has been working jointly with the Ministry of Health on improvement of perinatal, neonatal and postnatal services in Gaza and West Bank to reduce maternal and neonatal deaths and developmental complications. Families with neonates and infants, including hard to reach families were targeted. Services were provided mainly through targeted post-natal home visiting in Gaza with referrals, and inclusive neonatal health core services in both West Bank and Gaza provided to all families. The significance of intervening in this area in Palestine is highlighted by the following facts:

- In 2011 about 121,150 babies were born in SoP, with a population annual increase rate of 2.9%. With this high birth rate, the services related to pregnancy and childbirth represents a large proportion of the total demand for health care.⁷⁰¹
- Most children's deaths are concentrated in the first month and first days of life.
- Available data on stillbirths in Gaza show a rate of at least 10/1000 births, almost a half being intra-partum related.
- The neonate mortality rate should be further reduced from 11 per 1000 live births, and it composes two thirds of the infant mortality rate and half of the under-five mortality rate
- Exclusive breastfeeding-one of the most powerful determinant of child health- is 39% (41% West Bank; 36 % Gaza).
- Significant gaps are in the quality of childbirth and neonatal services and on the access to postnatal care,
- Total fertility rate is still high, at 4.2 during 2005-2010, compared to 6 in 1997. A high number of pregnancies per woman and short birth spacing are two important factors associated with maternal deaths and complications

1

- e Maternal mortality in Gaza estimated in 2015 was 45 in 100,000 live births. In 2009, 60% of total maternal deaths in both WB and Gaza Strip were associated to Caesarean Section (CS). In MOH hospitals, the risk of death associated with CS was found to be six times higher than the risk associated with normal delivery
- e The routine discharge of mothers and babies from hospital after childbirth happens within 2-3 hours from the time of delivery. In most cases, mothers and babies are not systematically assessed nor is the mother counselled on her and her baby's health, nutrition and care. The early discharge is explained by the limited space/bed availability and the scarce number of staff, compared to the enormous number of deliveries performed. Also, mothers are generally eager to limit their stay at hospital to the minimum given the usual non-friendly environment in delivery wards and their willingness to join their protecting and supporting relatives.
- e Post-natal care services provided through the Primary Health Care centres are unable to offer the continuum of quality care to mothers with new-borns. The average time when discharged mothers seek postnatal care at the health facility is beyond one week after birth, while most of neonatal maternal and new-born health problems occur during the first week.

⁷⁰ Palestinian health report 2015 [http://1/moh.ps/Content/Books/FDVFRuU50RoxrOoq4C5Q987o3GBwi/DpumLafURDQJcT7qqdf9Yk13UEpLZXH64\\$so0SyrQeQIET701jGkpE1QXz4](http://1/moh.ps/Content/Books/FDVFRuU50RoxrOoq4C5Q987o3GBwi/DpumLafURDQJcT7qqdf9Yk13UEpLZXH64$so0SyrQeQIET701jGkpE1QXz4)

8MqImMZxIgFpARQZQdE.pdf

Therefore, in 2011, UNICEF started supporting the Ministry of Health (MOH) in Gaza to implement the Postnatal Home Visiting Program (PNHV) for most vulnerable mothers and new-borns immediately after early discharge from the maternity ward. The PNHV programme was designed to respond primarily to the basic needs of high risk pregnancies according to the criteria such as pregnancy related diseases, caesarean section and prematurity.

The first PNHV conducted within the 48-72 hours after delivery ,then second and third PNH follow-up visits has

conducted according to the mothers and babies' needs assessed during the first PNHV.

In order to respond to the huge needs of mothers and new-borns for the post- natal health care services,in

2014 UNICEF supported scale up of PNHV service through partnership with NGO Near East Council of Churches(NECC) and ensured provision of PNHV services for mothers and new-borns from most deprived areas in Gaza. The PNHV services were scaled up further in 2015,with UNICEF support to the local NGO Union of Health Worker Committee (UHCW).

In 2016,UNICEF in close coordination with the MOH, NECC and UHCW continued supporting the targeted postnatal home visiting services for high risk pregnancies in Gaza, and Some 6,287 high risk women and their new-borns were reached since in 2016,which is about 60 per cent of the 2016 target, through PNHV services.

The Neonate Health Care services:

In 2011, UNICEF commenced providing support to the neonate improvement intervention in West Bank and Gaza. The intervention was designed to improve the neonate health care services at facility level, with special focus on secondary care at hospitals. Since then, 11 governmental hospitals in both West Bank and Gaza has received technical support including refurbishment of neonate units, space wise expansion of neonate units, provision of advanced technology and hi-tech equipment such as Continuous Positive Airway Pressure(CPAP) units, double -wall incubators, phototherapy units,transport incubators among many other essential equipment.

In addition, UNICEF supported capacity development of medical teams,both doctors and nurses on the latest advanced neonate health care, following the MoH developed protocol to unify the practices at hospitals. In service training and bed side training from Al Makased hospitals was also organised, in addition to two-month fellowships for staff from Gaza to Al Makased to improve the competencies of resident doctors and paediatricians at Gaza neonate units. A total of 285 doctors and nurses were trained up to 2015 in all 11 hospitals,

with additional training offered in 2016 reaching a total of 320 doctors and nurses in Gaza hospitals.

The renovation and construction of two neonate units (Rafah and Khan Younis) hospitals commenced in 2016, expanding the neonate intensive units with a total of 20 incubators at both hospitals increasing the overall capacity of neonate services in Gaza benefiting 8,500 neonates.

The project had a policy support in the National Health Strategy, and it is a key component of the National Early Childhood Development and Early Intervention Strategy 2017-2022 which envisages the scale up of targeted intervention for vulnerable families with young children focusing on children under high risk of developmental delays and disabilities through home visiting and provision of improved quality services to mothers, neonates and infants.

The State of Palestine continues to be in protracted crisis and UNICEF will carry on providing support in neonatal and postnatal services in Gaza and West Bank to reduce maternal and neonatal deaths and developmental complications focusing on those in need.

A thorough and participatory evaluation of previous UNICEF supported intervention in the area is needed at this stage to strengthen UNICEF's further response by learning from the support provided in the neonatal and postnatal health care services between January 2011 and December 2016. The evaluation is expected to measure the impact of supported interventions on child and mother and to bring on board the views of all stakeholders. The recommendations should inform both the Area Programme Document 2018-2022 through developing the Theory of Change and global research on lessons learned and experiences to ensure improvement of the programme design and enhanced outcomes among children and mothers.

The key UNICEF supported interventions of the postnatal home visiting and neonate care services improvement programme included the following inputs;

1. Training of midwives and community health workers on postnatal care skills and home-based child health care.
2. Provision of postnatal home visit kits, which were distributed for midwives conducting the field visits.
3. Home visits conducted targeting high risk pregnant women and their newborns, 24 hrs following the delivery. Followed by second and third visits conducted 72 hours and first week intervals.

4. Support the rehabilitation of neonatal units at Shifa, Ramallah, Nablus, Tulkarem, Qalqilia, Rafah and

Khan Younis Hospitals including the provision of needed medical and surgical equipment

2. PURPOSE OF THE ASSIGNMENT

The main purpose of the consultancy is to determine the relevance, efficiency, effectiveness and impact of the PNHV Services (Programme) on reducing postnatal maternal and neonatal mortality in Gaza. The assessment of the relevance, efficiency, effectiveness and impact of the Neonate service (Programme) on reducing postnatal maternal and neonatal mortality in West bank and Gaza depends on availability of funding, and if money available this assessment will be commissioned in the second phase. The evaluation will look at alternative implementation, future strategy and lessons learnt of the Programme.

The findings of the evaluation will be valuable to redirect and adjust the government, UNRWA and UNICEF response to postnatal and neonatal health care services in Gaza and West Bank. The evaluation will look at the Programme as a whole to identify good practices and areas for improvements, this will guide the way forward for Programme and guide the scale up of certain components of the Programme that is most effective while ensuring a holistic, comprehensive programme informed by evidence. The evaluation will be an important opportunity to document effectiveness and outcomes/impact of the PNHV programme in the Gaza that it is piloted in.

The evaluation will be mainly used by the Ministry of Health, UNRWA and other stakeholders to reconsider their strategies in improving the quality neonatal and postnatal services particularly focusing on most vulnerable families and families with young children hard to reach. UNICEF State of Palestine Country Office will use the evaluation to adjust the support to the MoH in provision of PNHV and neonatal services and guide the scale up the Programme. Regional Office, global Health and Nutrition working groups and other health actors will use the evaluation as a case study for programmes that managed to reduce postnatal maternal and neonatal mortality. Secondary audiences include donors and media, as the findings will also be used for reporting and advocacy purposes.

More specifically, implementation of this evaluation will aim for the following key specific objectives:

1. To assess the **relevance** of the Program and in particular the PNHV services provided in Gaza for the high risk pregnant mothers and neonates implemented in Gaza to national priorities and strategies to combat postnatal maternal and neonatal mortality from

the viewpoint of policy makers, service providers, and its relevance to the needs of children, mothers, families and communities, taking into account the appropriateness for and social acceptability by health facilities management, children, families and communities.

2. the high risk pregnant mothers and neonates implemented in Gaza as well as neonatal health care services supported in both Gaza and West bank and to measure to what extent the program has achieved its set results, including behavior change among mothers and health professionals in the health facilities and homes targeted. The research will compare the effectiveness of the program in the various **settings**, boys/girls; Gaza/West Bank. The evaluation will conduct a comparison between the implementation of the Program in different contexts to analyze supporting and hampering factors that are in these contexts.
3. To assess the **efficiency** of the Program and in particular the in particular the PNHV services provided in Gaza for the high risk pregnant mothers and neonates implemented in Gaza as well as neonatal health care services supported in both Gaza and West bank and to what extent the program has used resources (human, financial and others) in an efficient manner, and do the achieved results justify the resource?
4. To assess the **impact** of the Program and its components in capturing changes (positive, negative, intended and unintended) and differences the program may have brought including a gender perspective. What has been the impact/effect of the program on mothers, health workers, parents, other groups?
5. To assess the **sustainability** of the Program and in particular the in particular the PNHV services provided in Gaza for the high risk pregnant mothers and neonates implemented in Gaza as well as neonatal health care services supported in both Gaza and West bank and its results, considering the likelihood of program sustenance in the absence or reduction of ongoing UNICEF and donor support. This is to be done by identifying the degree to which the Program has built on existing institutional and local capacities, and a potential exit strategy.
6. To document **lessons learnt** and good practices that will inform future programming and propose recommendations to deliver the Program in a more effective, efficient and sustainable way, and possible scale up of the Program, suggesting different options for UNICEF, Ministry of Health and partner organizations. Theory of change will be developed retrospectively for the Post Natal Home Visiting and Neonate Care Services Improvement Programme and will contribute to strategizing the APD 2018 and 2022 with focus on most vulnerable and hard to reach young children and families.

Scope of work

The evaluation will focus on all aspects of PNHV program supported in Gaza. The time period under evaluation will be from the start-up of the Program in 2011 to end of 2016. At the second stage which depends on available resources the evaluation will focus on neonatal program in Gaza and West Bank.

The participatory approach should be central in the evaluation, ensuring the voices and views of all stakeholders are reflected. While all stakeholders are important, special emphasis will be placed on mothers with children and families, and their perceptions around the programme in their community environment. Within the selected households and health institutions to be part of the evaluation, different target groups will be included in the exercise, including male and females, health professionals, home visitors, directors, and other stakeholders such as community leaders.

Evaluation criteria and tailored evaluation questions

The evaluation will focus on the results of the PNHV (Programme), and provide evidence-based analysis in order to answer the following questions that are clustered by evaluation criteria below. It should be noted that the questions will be finalized in the inception phase.

Programme relevance/ appropriateness

Key questions:

- a) How relevant is the Programme strategy with regards to the overall national priorities?
- b) To what extent is the Programme and its components are in line with the relevant national strategies and programmes?
- c) How relevant and appropriate are Programme interventions in responding to 1) demand and needs of mothers and children (differentiated by gender) and including all most vulnerable and hard to families and neonates and infants.

Programme efficiency

Key questions:

- a) How adequately trained nurses have improved their practices?
- b) How adequately mothers/caregivers have adopted improved care seeking practices and nutritional habits?
- c) To what extent UNICEF's implementing partners were able to implement the interventions?
- d) What capacity/ expertise is in place or does it require additional /different capacity or resources?
- e) To what extent were funds used in a cost efficient manner in order to optimize the Programme outcomes?
- f) How systematically have the funds been allocated/utilized {across administrative levels and programme
- g) strategies/activities) to realise Programme objectives?

Programme effectiveness

Key questions:

- a) What are the major achievements contributable to and lessons learned from the Programme; which strategies have yielded good results? What are the gaps that need to be addressed? Develop retrospectively the theory of change for the Programme and identify which changes didn't contribute to the desired results
- b) Were the stakeholders targeted in the Programme activities the most relevant and how were selection criteria developed and used?
- c) What are the key successes achieved of the Programme?
 Are the key successes well documented and disseminated?
 Has the knowledge acquired through this programme was put to use to improve programme implementation and decision-making process (i.e., adjusting the planned results/targets, shifting programme focus)?
 To what extent and in what ways partnerships were strengthened amongst various parties including Government, NGOs and others to reduce high risk pregnancies i.e. religious leaders; community members?
- d) To what extent was the Programme successful in using key elements of result-based planning and management?

Programme impact

- a) Has the programme impacted children development? How does the Programme support mothers to cope with postpartum depression, breastfeeding and responsive parenting including creating a positive learning environment?
- b) What lasting changes can be identified in the mothers and children's behaviors, health professionals and home and health environment,
- c) To what extent has the Programme contributed to decreasing neonatal mortality and morbidity? Has the programme been able identify and reduce the causes of high risks for pregnancies, neonates and infants; sociocultural norms; over crowdedness of health facilities; traditional norms at level of home and communities; and gender inequality in access to quality health services? To what extent did the Programme contribute to increasing knowledge of service providers and practices in addressing high risk pregnancies, and providing adequate care to high risk neonates and infants; what extent did the Programme contribute to transformative behavior change among parents?

Programme sustainability

The evaluation will assess administrative, institutional, technical and financial sustainability and explore possible opportunities for expansion of the PNHV programme:

- a) What are major factors that influence the achievement or non-achievement of sustainability of the programme outcomes?

What conclusions can be drawn regarding sustainability and expansion/replicability of the approaches used? What are the issues and options related to the feasibility for replication and expansion?

To what extent the Government and UNRWA were engaged and owns the PNHV programme at the national and sub-national levels? How likely the government and particularly MoH and UNRWA can sustain and replicate the programme interventions without direct UNICEF technical and financial support?

What is the ministry plan to sustain the PNHV services? What are the regulation and policies alignment to sustain the services? Need to look at financial, human resources, etc.

What measures have been taken to document the lessons learned to allow for sharing with government and donors for further scaling up and replication?

- b) To what extent have programme decision making bodies and implementing partners undertaken the necessary decisions and course of actions to ensure the sustainability of the effects of the programme?
- c) What is the contribution of the Programme to putting in place systems at health institutions, directorate and national level for monitoring and following up on high risk pregnancies and neonates, infants that are under high risk?
- d) To what extent did the programme contribute to the capacity of all stakeholders at community, health

Directorate and organizational (including ministerial) level to address the issue of high risk pregnancy, neonates and infants?

Additional Evaluation Questions (Cross-cutting issues)

Human rights-based approach in programming (HRBAP) and gender equality:

- a) How successfully were the key principles of HRBAP applied in planning and implementing the Programme? In particular:

To what extent were the national and local context (knowledge, beliefs, gender and cultural differences) taken into account when the Programme was designed?

- b) To what extent has the Programme contributed to equity, including gender equity?

Which groups of children benefited and which did not? Why?

Were there differences in programme outputs related to sex, different groups (i.e. Gaza, urban, etc.), economic status, and geographic location?

What specific activities have taken place across the Programme by UNICEF and other partners to

facilitate the inclusion of children with disability?

To what extent gender equality existed in participation, decision making and access throughout the program cycle?

3. METHODOLOGY

To achieve the evaluation objectives and answer the evaluation questions, the evaluation should be quasi experimental mixed-methods design using both quantitative and qualitative methods of data collection and analysis. For the quantitative data collection, probability sampling will be used so as to be able to make statistical inferences about the target population. An outcome evaluation, using quantitative measures will be employed to compare outcomes between intervention or case in households where intervention was provided and comparison groups without interventions. This will be supplemented with an evaluation of the implementation process in intervention households to compare implementation features using quantitative methods as well as by stakeholder feedback and experiences using qualitative interviews. The comparison will be between determined case households that received support and implemented services (between 2011 and

2016): versus determined comparison households without services and interventions. For the qualitative data

collection the local NGO and home visitors who provided services will be engaged in organizing and collecting data from mothers and children through a mixture of focus group interviews, key informant interviews using semi-structured questionnaires, applying instruments below for measuring the impact of interventions on child and mother such as child development and growth, parenting knowledge and practices pertaining to feeding, hygiene, early stimulation, parenting stress and quality of the home environment.

List of some Instruments:

1. Ages and Stages Questionnaire
2. CDI: Communication Development Inventory
3. HOME: Home Observation for Measurement of Environment-Infant/Toddler
4. OMCI: Observation of Mother-Child Interaction
5. MacArthur CDI (8-16 months; 17-38 months)
6. IYCF: Infant and Young Child Feeding
7. Child growth: HAZ: Height for age z-score, WAZ= Weight for age z-score, WAZ

8. PSI: Parenting Stress Index
9. SES: Socio-economic Status
10. SRQ: Self- Reporting QuestionnaireThe consultancy firm can propose additional methods to collect the necessary data.

Ethical principles and premises of the evaluation

The evaluation process will adhere to the United Nations evaluation norms and standards available at: http://www.uneval.org/normsandstandards/index.jsp?doc_cat_source_id=4 and ethical guidelines for evaluation http://www.uneval.org/papersandpubs/documentdetail.jsp?doc_id=102

The assignment to be carried out according to the ethical principles, standards and norms established by the

United Nations Evaluation Group (UNEG).

1. **Anonymity and confidentiality.** The evaluation must respect the rights of individuals who provide information, ensuring their anonymity and confidentiality.
2. **Responsibility.** The report must mention any dispute or difference of opinion that may have arisen among the consultants or between the consultant and the commissioner of the evaluation in connection with the findings and/or recommendations. The team must corroborate all assertions, or disagreement with them noted.
3. **Integrity.** The evaluator will be responsible for highlighting issues not specifically mentioned in the TOR, if this is needed to obtain a more complete analysis of the intervention.
4. **Independence.** Evaluation in the United Nations systems should be demonstrably free of bias. To this end, evaluators are recruited for their ability to exercise independent judgement. Evaluators shall ensure that they are not unduly influenced by the views or statements of any party. Where the evaluator or the evaluation manager comes under pressure to adopt a particular position or to introduce bias into the evaluation findings, it is the responsibility of the evaluator to ensure that independence of judgement is maintained. Where such pressures may endanger the completion or integrity of the evaluation, the issue will be referred to the evaluation manager and, who will discuss the concerns of the relevant parties and decide on an approach which will ensure that evaluation findings and recommendations are consistent, verified and independently presented (see below Conflict of Interest)2.

5. **Incidents.** If problems arise during the fieldwork, or at any other stage of the evaluation, they must be reported immediately to the evaluation manager. If this is not done, the existence of such problems may in no case be used to justify the failure to obtain the results stipulated in these terms of reference.
6. **Validation of information.** The consultant will be responsible for ensuring the accuracy of the information collected while preparing the reports and will be ultimately responsible for the information presented in the evaluation report.
7. **Intellectual property.** In handling information sources, the consultant shall respect the intellectual property rights of the institutions and communities that are under review. All materials generated in the conduct of the evaluation are the property of UNICEF and can only be used by written permission. Responsibility for distribution and publication of evaluation results rests with the Country Office. With the permission of the agency, evaluation consultants may make briefings or unofficial summaries of the results of the evaluation outside the agency.
8. **Delivery of reports.** If delivery of the reports is delayed, or in the event that the quality of the reports delivered is clearly lower than what was agreed, the penalties stipulated in these terms of reference will be applicable.

In line with the Standards for UN Evaluation in the UN System, all those engaged in designing, conducting and managing evaluation activities will aspire to conduct high quality and ethical work guided by professional standards and ethical and moral principles.

Stakeholders

The targets and users of the evaluations are the key implementing partners, service providers and beneficiaries of the UNICEF supported interventions in postnatal and neonatal health care s that have direct relation with UNICEF such as :

Governmental Bodies such as Ministry of Health, Primary Health Care centers and hospitals will have the

consultative, steering and validation role, non-governmental bodies such as: Near East Council of Churches anion of Health Worker Committee, affected population (girls, boys, women and men) will have the consultative and validation roles, UNICEF and Donors.

Resources for desk review

The following resources are secondary data that will be made available by UNICEF. The Evaluation should consider: UNICEF's programme documents from the period from 2011 to 2016 such as the UNICEF Country Programme Action Plans, UNICEF's Area Programme Document, UNICEF Work Plans, UNICEF annual reports, UNICEF Situation reports and

Situation Analysis, NECC and UHWC reports, MICS reports, Disability study Report, access to hospital trend data on morbidities and mortalities, birth.

Limitations: NO baseline

4. MAJOR TASKS TO BE ACCOMPLISHED AND TIMEFRAME:

International consultancy firms are encouraged to identify local sub-contractors. UNICEF is willing to share a list of potential local consultants if needed.

Below is a list of tasks that the consultancy firm needs to carry out: Data collection and entering will be done by local subcontractors. The international firm will be responsible for mentoring and supervising data collection and entering from a distance.

SPECIFIC TASKS for PNHV service evaluation	Timeline
1.Desk review of relevant documents and reports;review the Post Natal Home Visiting Services programme documents and develop	Week 1
2.Conduct initial workshop with UNICEF staff and MOH,as well as relevant partners,including the Near East Council of Churches and Union of Health Work Committees to agree on the methodologies for the evaluation	Week 2
3.Develop an inception report and presentation on methodologies for the evaluation including an evaluation design and protocol, the research instruments and sampling framework, interview questions and analysis plan, and outline of the final evaluation report, based on the evaluation questions and UNICEF's	Week 2-3
4.Contract local company which will be responsible for field work and data collection and entering	Week 1-3
5.Conduct 2-day training of field workers on data collection and pretest of questionnaire/interview design and data entering one	Week4
6.Verified and methodology with UNICEF and key implementing partners; Finalized the impact evaluation methodology and instruments,fieldwork and data analysis (data entry, validation,	Week 4 and 5
7. Collect and enter both quantitative and qualitative data from children, mothers and other stakeholders	Week4-10
8. Analyze the data collected	Week 10-11
9. Presentation to steering committee on preliminary findings.	Week 12
10. Develop draft evaluation report	Week 12-13

11. Prepare for an end-of-evaluation validation workshop with stakeholders to present the preliminary findings and recommendation in order to obtain feedback and verification of overall findings.	Week 14
12. Finalize the evaluation report with recommendation and Theory of change retrospectively for the Post Natal Home Visiting Services Improvement Programme" focusing on early childhood health, development and wellbeing. Submit it to UNICEF on time together with all primary data and information collected.	Week 14-16
13. Prepare presentation and conduct an advocacy event with key policy makers UNICEF and relevant national stakeholders	Week 16
14. Publish paper on the evaluation results in academic publications	Week 16

5.DELIVERABLES AND DEADLINE(\$) FOR SUBMISSION

The expected outputs for the evaluation will be in English language and are the following:

- 1) A half-day workshop to select which components to evaluate in depth. (Week2)
- 2) An inception report (Week 2-3)
The inception paper includes the following, among others
 - o *Evaluation pion including timelines and activities*
 - o *Methodology including o matrix with o row for each question and columns for*
 - o *Doto collection instruments (qualitative and quantitative)*
 - o *Doto entering programme*
 - o *Interview and workshop pion*
- 3) Primary data submitted: the collected data files (both quantitative and qualitative) is and cannot be used for other purposes without written agreement UNICEF.
- 4) Preliminary findings presentation (Week 12)
- 5) Draft report (Week 13)
- 6) End-of-evaluation validation workshop with stakeholders (week 14)
- 7) An evaluation report (week 16)
- 8) End of Evaluation workshops with stakeholders (week 16)
- 9) Published paper on the evaluation results in academic publications

The report shall be structured as per the UNICEF-Adapted UNEG Evaluation Reports Standards:

1. Executive summary
2. Object of evaluation
3. Evaluation purpose, objectives and scope
4. Evaluation methodology

5. Findings
6. Conclusions and lessons learned
7. Recommendations

More detailed information of the UNICEF-Adapted UNEG Evaluation Reports standard is provided in the UNICEF Global Evaluation Report Oversight System (GEROS) Review Template, which will be shared at the start of the Consultancy. The ownership of the final report will be with UNICEF and the report will be made public.

6. ESTIMATED DURATION OF CONTRACT AND TERMS OF PAYMENT

First Phase: 16 weeks for PNHV services

The mode of payment will be as below:

1. First payment of 30 per cent will be paid upon acceptance of the inception report
2. Second payment of 30 per cent will be paid upon the presentation preliminary data and draft report.
3. Final payment of remaining 40 per cent will be paid upon the acceptance of the final report.

4. Duty Station: Jerusalem

5. Official Travel for international consultant Involved:

1st In country mission 6 day (3 days in
Gaza)

2nd in country mission 6 day (3 days in
Gaza)

7. QUALIFICATION OR SPECIALIZED KNOWLEDGE/EXPERIENCE REQUIRED

Team leader:

- Education: At least Master's degree in maternal and children's health and development

Work Experience:

- At least 10 years' experience in evaluation, including children's health and development
- Proven supporting documents of analytical reports and academic publications in the field of MCH and ECD and operational research.
- Previous knowledge and experience in evaluations the experience in evaluating the neonatal and postnatal home visiting services, measuring the impact on children and families, evaluation methods and data-collection is an asset.
- Experience in Palestine

Specific competencies required:

- Excellent English writing skills
- Project management experience
- Qualitative and quantitative skills

Education: Graduate degrees in relevant fields. Specific competencies required:

- Sound understanding and knowledge of technical aspects on Mother and Child Health and Early Childhood Development services/programmes
- Sound understanding of maternal and child health nutrition and development
- Sound understanding of child, women's rights and gender mainstreaming
- Sound understanding of family caring practices
- Sound understanding and knowledge of participatory and community-based approaches.
- Strong written and oral communication skills
- Project management skills
- Qualitative and quantitative skills
- Analytical skills

Team composition:

- Gender balanced team
- Availability of senior evaluator with access to Gaza

Languages: English, Arabic an added advantage

Selection Criteria

Aspect	Criteria	Point
Team leader	Significant experience in maternal and children's health and development evaluations	20
	Excellent English writing skills	10
	Project management experience	5
	Qualitative and quantitative skills	5
	Relevant post graduate degree	5
Whole team	Experience in similar evaluations	10
	Ability to analyse quantitative survey data	5
	Fluency in Arabic and English	5
	Experience and understanding of local context	5
	• Quality control system	5
	Experience in quantitative research methods	5
	Availability of senior evaluator with access to Gaza	20
	Gender balance	5
Methodology	Adequate methodology proposed	5
	Good understanding of risks and constraints	5
	Adequate implementation timeframe	5
Price	30 x(times) cheapest/bid price	30
Maximum possible score		150

Roles and Responsibilities

Primary supervision will be provided by a M&E Specialist in close cooperation with the Chief Health and Nutrition programme in the UNICEF State of Palestine office in Jerusalem.

The Health and Nutrition section will facilitate and manage operational requirements which entails providing project documentation as needed for the evaluation.

The Steering Committee, which is comprised of UNICEF, the government and NGO implementing partners, will provide technical inputs and facilitate access to the project sites and affected population.

UNICEF Health and Nutrition section will make formal/informal contacts with stakeholders as necessary as well as logistics and operational support in conducting interviews/focus group discussions and/or organizing the end-of-evaluation workshop. UNICEF will also be responsible for disseminating the findings to relevant stakeholders.

The UNICEF Regional Office will provide technical assistance to the UNICEF Country Office in developing the TOR for the evaluation, review of inception and final reports. The Consultant Firm will be responsible for the timely production of evidence-based evaluation, including recommendations to quality standards.

Ethical Issues

UNICEF directive on Ethical Standards will be shared with the contractor and should be strictly followed.

All interviewees, including children, should be informed about the objectives of the evaluation and how findings will be used; they also should be informed that collected data and any statement about the programme will be kept confidential and respondents will not be named or identified in the reports with regard to their statements.

All interviewees should agree without coercion to take part in the evaluation and be given the option to withdraw or not to participate at any time during the process. Interviews shall be carried out in line with interagency evaluation project interview good practice guidelines.

All gathered data should be confidential and names of individuals deleted from the data and replaced by codes in the evaluation notes.

Ownership of all data/information/findings gathered, databases and analysis prepared for the evaluation lies with UNICEF. The use of the data/information /findings for publication or any other presentation or sharing can only be made after agreement with UNICEF.

GENERAL CONDITIONS (PROCEDURES AND LOGISTICS)

- I. The selection process for the consultancy firm will strictly follow UNICEF's internal procurement rules

2. UNICEF will provide assistance where possible for necessary access and permits required for the evaluation
3. The firm will provide fortnightly verbal or short email progress updates and have review meetings
with UNICEF on monthly basis (face to face or phone meetings)
4. The firm will provide draft report for review and amend as requested before submitting the final report
5. UNICEF may request that the Consultancy firm submit original copies of all evaluation tools, discussion and interview guides, sampling procedures, field notes, completed questionnaires and any other material related to the implementation of the evaluation.

UNICEF will not provide office space to the team. All requirements including venues for workshops, transportation, visa, health insurance, secretariat services, interpreter, translator, etc., will not be covered by UNICEF unless agreed in writing between UNICEF and the Consultant. UNICEF office will provide any documentation, letters to government, etc., to make sure that the evaluation is conducted in good conditions.

II. PART TWO -Internal (UNICEF)

1. Programme Area and specific Project involved:

Programme: Health & Nutrition

Project and activity codes: 4.2.1 0 Conduct external evaluation of PNHV and NN Health care services Work Plan Activity: 4.2.1 0 Conduct external evaluation of PNHV and NN Health care services Budget Code/PBA No: Non Grant & SC149901

2. Contract Supervisor: Selena Bajraktarevic, Chief Health and Nutrition
3. Estimated amount budgeted for this Activity: Grand total 103,066 USD

Prepared and certified by:




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Name: Selena Bajraktarevic, Chief Health and Nutrition UNICEF SoP


Date: ..:1.... . 't;. 9..\1-

Endorsed by:

Signature: 

Name: Anne-Claire Dufay, Deputy Special Representative UNICEF SoP

Date::1. ./ .!";:.....

Approved by: 

Signature:

Name: Genevieve Boutin ,Special Representative UNICEF SoP

Annex 2 Evaluation framework

Q#	Questions & Sub-Questions	Indicators & Information to be Gathered	Information Sources	Data Collection Methods and Tools	How Findings Will be Reported
1.	Project Impact: What has been the impact of UNICEF's PNHV program on mothers, health workers, families/ communities and others? (with special attention for gender perspectives and for unintended impact)				
	<p>1a. Has the program contributed to decreased neonatal morbidity and mortality?</p> <p>1b. Has the program contributed to decreased maternal morbidity and mortality?</p> <p>1c. Has the program contributed to increased uptake of family planning?</p> <p>1d. Has the program contributed to increased practice of responsive exclusive breastfeeding and early stimulation, and knowledge on importance of positive parenting for early childhood development ?</p> <p>1e. Has the program contributed to increased immunization coverage?</p> <p>1f. To what extent has the program been able to change social and traditional norms at homes and communities?</p> <p>1g. Which unintended consequences of the program can be identified?</p>	<p>1a Neonatal mortality rate and indicators of morbidity (proportion of children under the age of 1 month with sepsis, anemia, jaundice)</p> <p>1b. Maternal mortality rate and morbidity during pregnancy or post-partum period (anemia, sepsis, hemorrhage)</p> <p>1c Family planning uptake; contraceptive prevalence rate in married women aged 15-49</p> <p>1d Exclusive Breastfeeding (EBF) rates in the first 6 weeks to three months of life</p> <p>1e Immunization coverage</p> <p>1f Norms and values about breastfeeding, harmful traditional practices, role of the father, immunization</p> <p>1g Unintended consequences encountered</p>	<ul style="list-style-type: none"> Health Annual Reports 2010-2015 (and 2016 when available) MICS 2010 and 2014 Publications from the Palestinian Central Bureau of Statistics Data from the Health Management Information System PNHV monthly and annual reports from MOH, NECC and UHWC Key stakeholders including women targeted and their spouses 	<ul style="list-style-type: none"> Analysis of Health Annual Reports Palestine of MOH, MICS report 2010 on morbidities, mortalities and birth In-depth interviews/FGDs with key informants, women targeted by the program and their spouses Analysis against the reconstructed ToC 	<p>Findings will be reported in the findings section of the evaluation report under each specific question. Finding 1 a – 1 e will be reported as quantitative findings, complemented by qualitative findings from interviews and FDGs. Findings around 1 f will be reported as qualitative findings.</p>

2.	Relevance: What is the relevance of the PNHV program to both national priorities & strategies, and to the needs of children, mothers, families and communities?				
	<p>2a What was the size of the problem of maternal and neonatal mortality (differentiate for sub-groups) in Gaza before the introduction of UNICEF's program?</p> <p>2b How did Gaza perform in terms of the relevant MDGs and national strategies?</p> <p>2c Was UNICEF's support, through implementation of the PNHV program, in line with national priorities and strategies to combat postnatal maternal and neonatal mortality.</p> <p>2d Was UNICEF's support, through implementation of the PNHV program, in line with the demands and needs of mothers and their infants, their spouses and families?</p> <p>2e Was UNICEF's support, through implementation of the PNHV program, in line with the demands and needs of the midwives and nurses trained as home visitors?</p> <p>2f Were the stakeholders targeted in the program activities the most relevant and how were selection criteria developed and used?</p> <p>2g Was there attention for national and local context (culture, beliefs, gender issues) in the program design?</p>	<p>2a and 2b Maternal and neonatal mortality, set against MDG targets and national strategies</p> <p>2c Home visit/improving post-natal care reported in national priorities and strategies</p> <p>2d Postnatal care in facility; at 48-72 hours after delivery; 1 week after delivery; 42 days after delivery</p> <p>2d and 2e: perspectives of mothers, their spouses and midwives on the activities</p> <p>2f number of women who received home visits set against the total number of high-risk pregnancies and the total number of deliveries (including still births) per year in Gaza; type of stakeholders involved; selection criteria of midwives involved</p> <p>2g Attention provided to culture, beliefs, gender in program documents and training</p>	<ul style="list-style-type: none"> • Health Annual Reports 2010-2015 (and 2016 when available) • MICS 2010 and 2014 • Publications from the Palestinian Central Bureau of Statistics • Country programme action plans, UNICEF area programme document, UNICEF work plans, UNICEF situation reports • Key stakeholders including women targeted and their spouses 	<ul style="list-style-type: none"> • Document review UNICEF program activities • Document review of national policies and existing data: e.g. Health Annual Reports Palestine of MOH, MICS report 2010 and 2014 • In-depth interviews with key informants involved in the PNHV, women targeted by the program and spouses of women targeted by the program • Focus group discussions with women targeted by the programme and health service providers • Analysis against the reconstructed ToC 	<p>Findings will be reported in the findings section of the evaluation report under each specific question.</p> <p>Where possible findings will be reported through a mix of quantitative and qualitative data</p>
3.	Efficiency: To what extent did UNICEF's work represent the best possible use of available resources (human, financial, other) to achieve results of the greatest possible value to recipients and the community?				
				<ul style="list-style-type: none"> • Document review 	<p>Findings will be reported in the findings section of the</p>

	<p>3a Were the resources made available by UNICEF for the program used in a cost-effective way to achieve its objectives?</p> <p>3b Were UNICEF's implementing partners able to implement the intervention as planned?</p> <p>3c What were enabling and hampering factors for program implementation in different contexts?</p> <p>3d Were there enough capacity and expertise in place for execution of the program?</p>	<p>3a resources made available against number of women reached</p> <p>3b activities implemented versus planned (including:</p> <p># home visitors (hv) trained/# hv planned to train</p> <p># trainings conducted/# trainings planned for)</p> <p>3c type of enabling and hampering factors mentioned</p> <p>3d type of capacity and expertise gaps reported</p> <p>3e type of coordination and collaboration mechanism in place</p> <p>3f type of capacity building activities versus number of high risk pregnancies reached</p> <p>3g type of adjustments made over time</p> <p>3h type of key elements of results-based planning used</p>	<ul style="list-style-type: none"> • UNICEF financial records and work plans • State government contributions and work plans • NECC and UHWC reports • Key stakeholders including home visitors 	<ul style="list-style-type: none"> • In-depth and semi-structured interviews with key informants and end-users • Focus group discussions with women targeted by the programme and health service providers • Analysis against the reconstructed ToC 	<p>evaluation report under each specific question. Where possible findings will be reported through a mix of quantitative and qualitative data</p>
4.	Effectiveness: Were the objectives of UNICEF's PNHV program achieved? (include unintended effects);				

<p>4a What are the major achievements and key successes achieved by the program?</p> <p>4b To what extent has the program contributed to:</p> <p>4b1 Increased knowledge and skills among home visitors in order to address high-risk pregnancies?</p> <p>4b2 Timely detection and referral of post-natal complications and other health problems among mothers & babies?</p> <p>4b3 Changed (transformative) behaviour among mothers, fathers and families in the homes, more specifically related to hygiene, nutrition, physical exercises, birth spacing and responsible parenting?</p> <p>4b4 Timely detection of post-partum psychological problems and support for mothers to cope?</p> <p>4b5 A positive learning environment to support mothers in breast feeding and responsive parenting?</p> <p>4b6 Mothers (and fathers) and their infants to attend follow-up visits in the health centre and comply with the immunization scheme?</p> <p>4b7 Mothers' (and fathers') awareness on the benefits of birth spacing and the options for family planning?</p> <p>4b8 Partnerships strengthening amongst various parties such as government, NGOs, and health facilities?</p>	<p>4a achievements and key successes mentioned</p> <p>4b changes in</p> <p>4b1 knowledge and skills</p> <p>4b2 timely detection and referral</p> <p>4b3 behaviour</p> <p>4b4 identification of and support to post-partum psychological problems</p> <p>4b5 positive learning environment for breastfeeding and responsible parenting</p> <p>4b6 # of follow up visits in health centre; immunization coverage</p> <p>4b7 Awareness on benefits of birth spacing and FP options</p> <p>4b8 Collaboration mechanisms in place</p>	<ul style="list-style-type: none"> • Health Annual Reports 2010-2015 (and 2016 when available) • MICS 2010 and 2014 • Publications from the Palestinian Central Bureau of Statistics • Data from the Health Management Information System • PNHV monthly and annual reports from MOH, NECC and UHWC • Key stakeholders including women targeted and their spouses 	<ul style="list-style-type: none"> • Document review of UNICEF program data • Secondary (re)analysis of Health Annual Reports Palestine of MOH, MICS report 2010 and 2014 on morbidities, mortalities and birth • Analysis of PNHV monthly and annual reports from MOH, NECC and UHWC • In-depth interviews with key informants and end-users • Focus group discussions with women targeted by the programme and health service providers • Analysis against the reconstructed ToC 	<p>Findings will be reported in the findings section of the evaluation report under each specific question. Where possible findings will be reported through a mix of quantitative and qualitative data</p>
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	<p>4c Were there differences in program outputs and outcomes related to sex, group characteristics (e.g. urban/rural), socio-economic status, geographic location? Which groups of infants benefited, which did not, and why?</p> <p>4d Has the program been able to address gender inequality in access to quality health services? Was there gender equality in terms of participation, decision-making, and access throughout the program cycle?</p> <p>4e Has the program been able to focus on different disadvantaged groups in terms of children with disabilities, gender, vulnerability and hard to reach families?</p> <p>4f To what extent did the program reach the right homes (in number and indication)?</p> <p>4g What are the gaps that need to be addressed for future program scale up?</p> <p>4h Which unintended consequences of the program can be identified?</p>	<p>4c postnatal care coverage versus socio-economic status; geographic location; sex of the infant</p> <p>4d and e number of home visits for male infants versus that of female infants</p> <p>4e number of home visits for infants with disabilities; infants from homes with less resources; infants from homes with mothers with less education</p> <p>4f number and frequency of home visits to high risk pregnancies versus other pregnancies</p> <p>4g gaps mentioned that affect scale up</p> <p>4h unintended consequences</p>			
5.	Sustainability: Are positive results from UNICEF's PNHV program likely to be sustained?				

	<p>5a How were sustainability concerns addressed in program design and implementation (i.e. built on existing institutional and local capacities, and looked into an exit strategy)?</p> <p>5b To what extent are enough capacity and resources available to support the scale up of the program within Gaza?</p> <p>5c What are factors influencing the sustainability of the program?</p> <p>5d Has the program put systems and regulations in place at directorate and national level for monitoring and following up on high risk pregnancies and neonates, infants that are under high risk?</p> <p>5e Have any of the stakeholders included the program activities, or follow-up to these, in their annual plans?</p> <p>5 f Have budgets been allocated for ongoing program activities in government, UN agencies' and (international) NGO budgets?</p> <p>5g To what extent does the government 'own' the program and is it engaged to sustain it both at the national and sub-national levels?</p> <p>5h To what extent does the program explicitly or implicitly aim to generate evaluative evidence or lessons that could be used in policy advocacy vis-à-vis governments and other development partners? Are the key successes well documented and disseminated?</p>	<p>5a Type of sustainability mechanisms put in place</p> <p>5b Type of capacity and resources available for scale up</p> <p>5c Type of factors influencing sustainability</p> <p>5d Type of systems and regulations put in place for monitoring and follow up of high risk pregnancies, neonates and infants</p> <p>5e inclusion of home based activities in stakeholder plans</p> <p>5f inclusion of home based activities in stakeholders budgets</p> <p>5 g Type of government commitment expressed (in documents/interviews)</p> <p>5h documentation and dissemination of successes of the program</p> <p>5i good practices identified</p> <p>5j lessons learned</p> <p>5k unintended consequences</p>	<ul style="list-style-type: none"> • MoH program implementation plans on national and regional level • SoP government (financial) documents • Key stakeholders including women targeted and their spouses 	<ul style="list-style-type: none"> • Document review • In-depth interviews with key informants • Analysis against the reconstructed ToC 	<p>Findings will be reported in the findings section of the evaluation report under each specific question. Where possible findings will be reported through a mix of quantitative and qualitative data</p>
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	<p>5i What good practices can be identified (including in relation to gender)?</p> <p>5j What lessons can be learned, including gaps and challenges, and strategic direction for UNICEF's contribution to the PNHV program and early childhood development particularly focusing on early detection of children with developmental delays and disabilities</p> <p>5k Which unintended consequences of the program can be identified?</p>				
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Annex 3 The evaluation team

Team composition



Pam Baatsen,
MA, KIT, Team Leader



Irene de Vries,
MD, KIT, Maternal &
Newborn health advisor



Sandra Alba,
MSc, PhD, KIT,
Epidemiologist



Hermen Ormel, MA, MPh,
KIT, Quality Assurance



Bassam Abu Hamad,
PhD, Associate Professor



Umalyeh Khammash,
Md, MPh, Juzoor



Malek Qutteina, MD, MPh, Juzoor



The updated team – due to access issues to Gaza is as follows

	Team leader PB (KIT)	Team member IdV (KIT)	Team member SA (KIT)	Team coordinator Juzoor UK	Team member BAH (Juzoor)	Team member MQ (Juzoor)	HO (KIT)
Team leader							
Significant experience in MCH and development evaluations	x	x		x	x		X
Excellent English writing skills	x	x	x	x	x		X
Project management experience	x			x			X
Qualitative and quantitative research/evaluations skills	x	x	x	x	x	x	X
Relevant post-graduate degree (or equal experience)	x	x	x	x	x	x	X
Team members							
Experience in similar evaluations	x		x	x	x	x	X
Experience in quantitative research methods	x	x	x		x	x	X
Experience in qualitative methods	x	x			x	x	X
Ability to analyse quantitative data			x				
Fluency in Arabic				x	x	x	
Fluency in English	x	x	x	x	x	x	X
Experience in and understanding of local context	x	x		x	x	x	X
Quality control systems	x			x			X
(Senior) evaluator with access to Gaza					x		
Gender balance (indicate sex of team members)	F	F	F	M	M	M	M
Specific competencies							
Sound understanding and knowledge of technical aspects of MCH and ECD services/programme	x	x		x	x	x	X
Sound understanding of MCH nutrition and development	x	x			x	x	X
Sound understanding of child, women's rights and gender mainstreaming	x	x			x	x	X
Sound understanding of family caring practices	x	x			x	x	X
Sound understanding and knowledge of participatory and community-based approaches	x	x		x	x	x	X

Core team

Pam Baatsen, M.A., Anthropology is the Team Leader. During her study, she also obtained teaching degrees in societal sciences and research methodologies, which she complemented with an university level teaching degree (BQU) in 2015. Over the last 24 years she has gained expertise in evaluation, qualitative and mixed methods research, capacity development, Sexual Reproductive Health and Rights (SRHR)/Reproductive Maternal Newborn Child Health (RMNCH), HIV prevention, youth and adolescents, and key populations. Pam has extensive experience in South and East Asia, Africa and the Middle East.

As Country Director for Family Health International in Bangladesh, Pam managed a period of significant growth in size and budget. She oversaw the HIV surveillance and research programme and translated findings into interventions. She also worked as Programme Officer for UNFPA in Ethiopia, and for UNICEF EAPRO in Thailand in the period 1996 - 2000.

At KIT Pam has led a range of large and complex evaluations, assessments and reviews, including in relation to children, adolescents and youth, SRHR, HIV and gender for amongst others UNICEF, the World Bank, and the Global Fund. Currently, Pam is team leader of an external evaluation commissioned by UNICEF New York of Child Health Days activities focused on improving the health and nutrition outcomes of under-five covering 13 countries in Sub-Saharan Africa. For UNICEF Malawi, she has spearheaded the situation analysis of vulnerable children in Malawi, and the subsequent translation of the situation analysis in a costed national plan of action for vulnerable children (2014 – 2018). For UNICEF Rosa, Pam has in 2015 lead the Joint Evaluation of HIV-Related Capacity Development Initiatives on Young Key Populations in Asia and the Pacific undertaken by the Interagency Task Force on Young Key Populations. She has also been the team leader of a concurrent impact evaluation (2009 – 2012) focussed on the quality of life of children in and affected by HIV and their families in 11 Districts of Andra Pradesh, India.

Pam has also helped to develop and implement the SRHR and HIV tracks within KIT's Master of Public Health Programme, as well as virtual learning courses on Sexual and Reproductive Health and Rights; and Health Systems Strengthening and HIV. She has also assisted the International Federation of the Red Cross and Red Crescent with the development of a Health Strengthening Strategy for Reproductive Maternal Newborn Child and Adolescent Health in 2015. She has also been involved in several Tailor Made Training courses on SRHR in India, Sudan, Kenya, Nepal and Mongolia.

Pam is particularly skilled in developing research and evaluation methodologies and methods, at research tool development and capacity strengthening activities with in-country partners. She has a proven track record as an insightful strategist adept at influencing and shaping successful interventions. She provides strong vision and leadership around strategic planning, implementation, monitoring and evaluation, training, capacity development and operational research. In addition, she is an integral team player who forms and guides effective partnerships with colleagues, clients and partners alike.

Irene de Vries (KIT) Irene de Vries is a Medical Doctor in International Health & Tropical Medicine and a social scientist (MSC) with a master degree in Medical Anthropology and Sociology. After her degrees, she worked several years as a medical doctor in the Netherlands, Caribbean and Zambia, mainly in the fields of obstetrics & gynaecology, neonatal care and pediatrics. She has substantial experience with antenatal, perinatal and postnatal care services for both mothers and newborns. As one of the leading doctors in a rural secondary care hospital in Zambia, Irene has taken care of an extentional amount of women with high-risk pregnancies, introduced programmes and new equipment to improve the obstetric and neonatal unit, developed local protocols, trained midwives and other health staff and supported them on outreach programmes.

Within the Royal Tropical Institute in Amsterdam she develops and implements advisory, evaluation and research projects related to SRHR in LMICs, with a focus on maternal and newborn health. Furthermore she is involved in educational, training and capacity building activities.

Sandra Alba, MSc, PhD, is an epidemiologist at KIT Health with a background in medical statistics. She has 12 years' experience in the application of statistical and epidemiological methods to evaluate public health programmes primarily in developing countries.

She obtained an MSc in Medical Statistics at the London School of Hygiene and Tropical Medicine in 2006, and soon after joined the Swiss Tropical and Public Health Institute to work on the monitoring and evaluation of a programme aimed at improving and understanding access to malaria treatment in rural Tanzania. After completing her PhD in 2010, she spent two years working as a clinical trial statistician in Switzerland. At the end of 2012 she joined the KIT as an epidemiologist. She has ample experience in study design, sample size calculations, developing data collection tools, co-ordinating fieldwork and data management, perform data analyses, report on study results and formulate public policy recommendations.

At KIT Sandra has specialised in the application of statistical and epidemiological methods M&E and impact evaluations within multidisciplinary teams and in collaboration with local partners in Africa and Asia. Her areas of expertise include child health, malaria, WASH and TB. Her responsibilities include co-ordinating the KIT 2-week summer course on monitoring and evaluation for health. She also teaches statistical and epidemiological methods to MSc students of the KIT Public Health programme and supervises students' final year theses.

Umaiye Khamash, Md, MPH, Juzoor is one of the founding members of Juzoor, and one of the senior managers of the organization based in Ramallah. In his long career, he has worked amongst others as the Director of the UNRWA Health Department for Palestine Refugees. Dr Umaiye will have a coordinating role from the side of Juzoor.

Bassam Abu Hamad, PhD, is an Associate Professor at School of Public Health, Al-Quds University in Gaza, and is based in Gaza. He is a Public Health and Human Resources Management specialist. He holds a Doctorate from Sheffield and is the former Dean of the Palestine School of Nursing. Dr Bassam has over 30 years of experience while working in different settings, including the Ministry of Health, Ministry of Social Affairs, universities, and NGOs. Within those years he has amongst others focused on management systems, information system, mother child health and nutrition strategies, human resource management, quality improvement, staff motivation, research,

monitoring and evaluation, program evaluation and humanitarian interventions. He also has extensive experience in developing health strategies/plans for large and small scale programs/organizations; including but not restricted to the HANAN Mother Child Health Project (in 2005; 21 Million dollar), MARAM Project (in 2001; 28 Million dollar), Union of Health Work Committees (4 subsequent plans-1985-2008), Women Affair Association (2010), Near East Council of Churches (2011), and lately leading the team who developed the Strategic Health Plan-Gaza (2014-2018). Furthermore, he also has extensive experience in conducting evaluation and monitoring activities in social protection, social policy and humanitarian interventions at the program level, project level and organizational level. This includes designing and conducting monitoring and evaluation activities.

Malek Qutteina (Juzoor) is a Medical Doctor with experience in child health. He has a Masters Degree in Public Health with focus on behaviour change. During an around 30 years of experience in the Palestinian health sector, he managed several health education campaigns on child health and development, trained community health workers and physicians and developed training and educational materials for health workers, families and school students on various issues related to childhood illnesses, breastfeeding promotion, child development and SRHR. He has been involved in several evaluation activities for different stakeholders, including international donor agencies supporting the Palestinian health sector.

Resource person for quality assurance

Hermen Ormel (KIT) is a public health specialist (MA, MPH) with expertise in the field of sexual and reproductive health and rights. His main areas of interest are capacity development, research and evaluation, mobile health, young people's needs and gender issues.

Hermen worked with UNFPA for several years, providing programmatic, technical and evaluation assistance to governmental and NGO counterparts. Between 2003 and 2008, he served as technical advisor with the Namibian Ministry of Health and Social Services, as part of the EU-funded Namibian HIV/AIDS Response Capacity Development Programme implemented by KIT.

Currently Hermen is the coordinator of KIT's theme group on sexual and reproductive health (SRHR). Recently he led a DFID-funded impact evaluation study on mobile health for maternal health (Sierra Leone); led the impact evaluation of a Dutch government-funded cervical cancer prevention and treatment programme in Nicaragua; and was key expert for the global evaluation of the UNFPA Support to Family Planning 2008-2013, that was completed in 2016. He was also involved in capacity building on leadership and management in South Sudan, as part of a Dutch Government funded three-year maternal health improvement programme. As Principal Investigator, he is currently involved in a five-year EU FP7 research project (Reachout) that addresses the performance of close-to-community services in Bangladesh, Ethiopia, Indonesia, Kenya, Malawi and Mozambique. Hermen also is overall co-coordinator of KIT's Master of Public Health program, in addition coordinating the course on SRHR Policy, Governance and Financing and teaching in other topics like Health Planning, Health Systems Research and SRHR.

Risk management

As evaluations of this size are complex, the evaluation team has put the following measures in place to reduce any risk.

In the first place, a team has been selected with complementary expertise, and with rich experience in conducting complex evaluations as well as in State of Palestine so that the team is well capable to make adjustments in case changing circumstances require this. In addition, the national consultants included in the proposal have deep links and contacts with the key stakeholders and health services, and one of the national team members is permanently based in Gaza. Furthermore, our methodology is focused on maximizing triangulation of data, this to ensure that the evaluation data will be robust and be able to answer the evaluations. Furthermore, our team is well skilled in conducting evaluations in participatory fashions with regular consultation with the organization the evaluation is conducted for.

Annex 4 The evaluation Steering Committee

Terms of Reference for Evaluation Steering Committee

For the UNICEF's program

Postnatal Home Visiting Program for Neonates, Infants and their families- SoP

Background

In 2011, UNICEF SoP, in collaboration with the Ministry of Health, supported programmes in order to improve perinatal, neonatal and postnatal services in the SoP and reduce maternal and neonatal mortality and developmental complications. Subsequently, the Postnatal Home Visiting Program (PNHV) for most vulnerable mothers and new-borns immediately after early discharge from the maternity ward in Gaza has been launched. This was designed to respond primarily to the basic needs of high risk pregnancies according to the criteria, such as pregnancy related diseases, caesarean section and prematurity. This program was scaled up in 2014 in collaboration with local NGOs (NECC and UHWC). Also, UNICEF supports improvement of Neonate Health Care (NHC) services at facility level, with special focus on secondary care at hospitals.

After six years of implementing the programme (PNHV), UNICEF SoP and its partners are keen to learn more what works and what doesn't work, be informed about the impact of the program on Palestinian families and use generated evidence to inform future programming. For this reason, UNICEF has commissioned an external independent evaluation. At this stage, the evaluation focuses on UNICEF's contribution to the PNHV program implemented in Gaza covering more than 7,500 households. If resources are available, in a second phase the evaluation will focus on the support to Neonate Health Care services, covering 11 neonatal units in both West Bank and Gaza.

More precisely, the purpose of this external independent evaluation is both summative and formative of character. Firstly, it is to inform the Ministry of Health, UNRWA, UNICEF and other stakeholders about the relevance, efficiency, effectiveness, impact and sustainability of the PNHV programme. Secondly, identification of good practices and areas for improvement will have to inform future programming. Furthermore health actors, such as global Health and Nutrition working groups, will be able to use the evaluation as a case study for programmes that reduce maternal and neonatal mortality. In addition, the findings will be used for reporting and advocacy purposes.

Importantly, the evaluation should reflect the voices and views of all stakeholders. A special emphasis is placed on mothers with children and their families, especially those in the most deprived areas in Gaza. Other stakeholders that will be involved in the evaluation are male and female students, home visitors, community health workers, community leaders, health care professionals, programme managers, and policy makers.

Purpose of the Evaluation Steering Committee

UNICEF SoP envisioned instituting an Evaluation Steering Committee to provide technical and logistic support and oversight to this evaluation exercise. The steering committee will play both a technical consultative role as well as managerial and policy oriented role as detailed in the bullet points below.

Responsibility of the members of the evaluation steering committee

- Commenting on the methodology, design and the implementation of this endeavour as proposed by the KIT/Juzoor team
- Ensuring that the proposed methodologies and tools adequately cover the scope and purpose of the evaluation under the broader perspective of UNICEF work and work of other agencies in the area of the postnatal health care, specified under the evaluation's TOR (OECD DAC criteria)
- Supporting the data collection processes through facilitating access to beneficiaries, sites, records and stakeholders
- Endorsing the evaluation outputs and agreed deliverables including inception report, tools, and final report
- Contributing to data dissemination , suggesting appropriate approaches it, and the uptake of findings by policy makers and stakeholders
- Ensuring that the evaluation is designed and implemented in adherence to the local and international ethical standards especially ensuring human protection and confidentiality
- Ensuring that the evaluation process is efficiently and appropriately implemented according to the action plans and providing support wherever needed
- Ensuring that the recommendations of the evaluation are adequately considered in future programming and policy setting
- Active participation in consultative and dissemination meetings related to this evaluation

Composition

The evaluation steering committee is composed of the following members

Organization	Representative
UNICEF	Shereen Obeed and Amani Juda-chair and secretariat roles
Ministry of Health	Dr Nahla Hellis and Azza Qaoood
NECC	Lubana Sabah
UHCW	Jehan Al Aklook
UNRWA	Dr Zohair Khaiteb
UNFPA	Osama Abu Eita
WHO	Etimad Abu Ward
External evaluation team (one member)	Pam Baatsen and Bassam Abu Hamad

Ways of working

- The steering committee will be chaired by the UNICEF. UNICEF will perform the secretariat role also.

- The steering committee will meet as needed especially during the inception period, data collection phase, and during the dissemination, as well as necessary.
- Decision making will be done by consensus wherever possible. In any case where an item remains undecided, the team will vote. A majority is decided by 50% members + 1.
- The meetings of the steering committee will take place at the UNICEF premises and through a provided conference line when needed.

Annex 5 Agenda Data Collectors training workshop
 Evaluation of a Postnatal Home Visiting Program for mothers, neonates and
 their families in Gaza, State of Palestine, over the period 2011 – 2016
 Draft Agenda for the data collection Training and Piloting

Place Salam Restaurant

Focus	Activity	Time	Who
First Day: Feb 4th 2018			
Welcoming, Introduction and overview about the evaluation	<ul style="list-style-type: none"> Overview of the 3 days training and piloting activity Introduction of participants Overview of the evaluation process, objectives, methodology, timeline Team composition/roles of different team members Role of international team members Key outputs 	9 – 10	Juzoor
	<ul style="list-style-type: none"> Short introduction by Skype 	10.00-10.10	KIT
	<ul style="list-style-type: none"> Questions and answers 	10.10-10.20	Juzoor
Coffee Break		10.20-10.30	
Overview about Post-natal care in Palestine/Gaza	<ul style="list-style-type: none"> Post-natal care in Gaza Definitions, coverage modalities of service provision, women at high risk, services, service providers, gaps MOH protocols 	10.30 -11.30	Juzoor
Description of the program	<ul style="list-style-type: none"> UNICEF PNHV program 	11.30 -12.00	Juzoor
Research ethics	<ul style="list-style-type: none"> Overview ethical considerations including consent forms 	12.00- 12.30	Juzoor
Principles and philosophies of qualitative research	<ul style="list-style-type: none"> Assumptions, principles of research/evaluation Types of Qualitative research Role of researchers 	12.30- 13.30	Juzoor

	<ul style="list-style-type: none"> Tools for qualitative research (FGDs and IDIs) Conducting FGDs and IDIs 		
Lunch break		13.30-14.30	
Interviewing techniques	<ul style="list-style-type: none"> Interviewing people Probing techniques Notes taking Role play 	14.30-16.30	Juzoor
Exercise and Wrap up	<ul style="list-style-type: none"> Conclusion Feedback Questions and answers 	16.30-17	Juzoor
Second day- February 5th 2018			
Review of yesterday's work	<ul style="list-style-type: none"> Review of yesterday work Reflection Questions and answers 	9-9.30	Juzoor
Sampling approach	<ul style="list-style-type: none"> Sample composition Recruitment of participants Approaching households 	9.30-10.30	Juzoor
Logistics arrangement	<ul style="list-style-type: none"> Transportation Communication Handling minutes and recordings Quality control measures 	10.30-11	Juzoor
Break		11-11.15	
Exploring the evaluation tools	<ul style="list-style-type: none"> Exploring evaluation tool and instructions Role play Discussions of the questions 	11.15-13.30	Juzoor
Lunch		13.30-14.30	
Exploring Research tool-continue	<ul style="list-style-type: none"> Exploring tool and instructions-continue Using role play 	14.30—16.30	Juzoor

	<ul style="list-style-type: none"> • Debriefing reports 		
Wrap up	<ul style="list-style-type: none"> • Wrapping up and overview of the coming day and request homework: going over the tools to make comments • Pilot arrangements 	16.30-17	Juzoor
Third day February 6th 2018			
Review of yesterday's work	<ul style="list-style-type: none"> • Reflection on the training of the first two days 	9-9.30	Juzoor
Arrangements for piloting	<ul style="list-style-type: none"> • Targets in piloting • Number • Localities 	9.30-10.0	Juzoor
Conducting piloting	<ul style="list-style-type: none"> • IDIs and FGDs 	10-15	Juzoor
Reflection and modification	<ul style="list-style-type: none"> • Review of piloting results • Agreeing on final arrangement 	15-17	Juzoor

Annex 6 Evaluation tools

Overview

- A) Topic Guide for In-depth Interviews with beneficiaries (mothers) who have had home visits
- B) Topic Guide for Focus Group Discussions with beneficiaries (mothers) who have had home visits
- C) Topic Guide for In-depth Interviews with mothers who did not have home visits
- D) Topic Guide for In-depth Interviews for fathers whose wives have been part of the PNHV program
- E) a. Topic Guide for Focus Group Discussions with midwives/nurses
b. Checklist home visits
- F) Topic Guide for In-depth Interviews with key stakeholders

A) Topic Guide for In-depth Interviews with Beneficiaries (mothers) who have had home visits

The purpose of this topic guide is to obtain the individual perspectives of the mothers who have had high risk pregnancies on the relevance, effectiveness, efficiency and impact of the home based visits through in-depth interviews.

Please note, that this is a topic **GUIDE** and will be used as such, meaning that the questions proposed provide guidance only and that it will be important to adapt the questions during the interviews in such a way that they make sense to the respondents. In addition, the tool will be piloted immediately following the data collection training, and modified subsequently.

Further instruction for use: Prior to the interview, please ensure informed consent has been arranged by using the informed consent form for interviews. Then start the interview. Also make sure that the interview is conducted in a site that is comfortable for the respondents, and that their safety is safeguarded amongst others by not including their names in the interview notes, on the tapes, but on a separate sheet.

Area of inquiry	Link to questions in evaluation framework	Guiding Questions
Introduction		<p>Please obtain the following background characteristics of the respondents:</p> <ul style="list-style-type: none"> • Age • Household composition (husband, alive children, children who died, other people living in the home) • Brief obstetric history, including when children were born • Name(s) of clinic(s) for antenatal care, delivery, post-natal care; distance to clinics; way of transport to clinic(s)
Inclusion of and relevance for women and their families	2d, 2f, 2g, 4d, 4e, 4f	<ul style="list-style-type: none"> • When was the first time you received home visits following delivery (with 1st child, 2nd child etc...). How many home visits did you get (following each pregnancy)? Did you go for a second and third visit to the clinic? Was that feasible for you? Could you have gone for the first visit to the clinic as well? Why/why not? • Who was with you when the home visitor came? (Probe for mother, mother-in-law, husband)? Were they involved during the visit? Able to ask questions? Did you get support from them afterwards? (especially probe about role husband, and whether the respondent would like him to be more involved, and why)) • How useful were the home visits for you? Why? • Which type of women in Gaza are most in need of home visits just after giving birth? (please probe around different types of high risk pregnancy; first pregnancy) Why them?

		<ul style="list-style-type: none"> Do you know why you were included in the post-natal home visiting program? How did you learn about this? What did you think about this?
Gained knowledge and practices	4b2-7, 2g	<ul style="list-style-type: none"> What are things you learned from the home visitor that you did not know or do before? (probe about hygiene; family planning; birth spacing; physical exercise; breastfeeding <i>(including the demonstration of breastfeeding; and tips and tricks around that)</i>; responsible parenting; and nutrition). (Probe if these things were really new, or whether they already learned this during antenatal care) Have you been able to change something following the home visit? (probe about hygiene practices; family planning (what contraceptive do you currently use or intend to use; perspective on spacing); physical exercise; breastfeeding <i>(exclusively until when?; obstacles to breastfeeding)</i>; responsible parenting (involvement husband); nutrition). Why where you (not) able to change? Have you ever been referred back to hospital through a home visit? Why? If not, do you think you should have been referred? Why (not)? Having a new baby is beautiful, but can be a burden as well. Have you had difficulties to cope with this at times? Feelings of low mood? Extreme fatigue? Sleeplessness? Have you been able to discuss these feelings with the home visitor? How was that? What did you do? Did it help? How often do you need to go to the clinic for check-ups for you and you baby? Are you able to go to these check-ups? Were you motivated by the home visitor to go for follow-up visits to the clinic and to get vaccinations for your baby? Did you feel respected by the home visitor? Why? Why not? (Probe for having enough time to discuss) What type of questions did you ask the home visitor? E.g. about what?
Impact	1f, 1g, 4g	<ul style="list-style-type: none"> Have the home visits helped to keep your baby and yourself healthy? How? (probe for breastfeeding; immunization; reduction of harmful traditional practices such as wrapping baby, or use of oil and salt on umbilical cord) Did the home visits help you with anything else? Did the home visits cause any problems? (unintended effects)
Future	4g, 5i-k	<ul style="list-style-type: none"> What would you like to recommend in terms of home visits? Why? Could social media play a role in supporting post-natal care? How?

B) Topic Guide for Focus Group Discussions with Beneficiaries (mothers) who have had home visits

The purpose of this topic guide is to obtain the perspectives of the mothers who have had high risk pregnancies on the relevance, effectiveness, efficiency and impact of the home based visits through FGDs.

Please note, that this is a topic **GUIDE** and will be used as such, meaning that the questions proposed provide guidance only and that it will be important to adapt the questions during the FGDs in such a way that they make sense to the respondents. In addition, the tool will be piloted immediately following the data collection training, and modified subsequently.

Further instruction for use: Prior to the FGD, please ensure informed consent has been arranged by using the informed consent form for FGDs. Then start the interview. Also make sure that the FGD is conducted in a site that is comfortable for the respondents, and that their safety is safeguarded amongst others by not including their names in the interview notes, on the tapes, but on a separate sheet.

Area of inquiry	Link to questions in evaluation framework	Guiding Questions
Introduction		Please obtain the following background characteristics of the respondents:

		<ul style="list-style-type: none"> • Age • Household composition (husband, number of children, other people living in the home) • Name(s) of clinic(s) for antenatal care, delivery, post-natal care
Inclusion of and relevance for women and their families	2d, 2f, 2g, 4d, 4e, 4f	<ul style="list-style-type: none"> • When was the first time you received home visits following delivery (with 1st child, 2nd child etc...). How often did you receive home visits? Would you have been able to go to the clinic instead of haven gotten home visits? • Who was with you when the home visitor came? (Probe for mother, mother-in-law, husbands)? Were they involved during the visit? Able to ask questions? Did you get support from them afterwards? (especially probe about support husbands) • How useful where the home visits for you? Why (not)? • Which type of women in Gaza are most in need of home visits just after giving birth? (please probe around different types of high risk pregnancy; first pregnancy) Why them? • Do you know why you were included in the post-natal home visiting program? How did you learn about this? What did you think about this?
Gained knowledge and practices	4b2-7, 2g	<ul style="list-style-type: none"> • What are things you learned from the home visitor that you did not know or do before? (probe about hygiene; family planning; birth spacing; physical exercise; breastfeeding <i>(including the demonstration of breastfeeding; and tips and tricks around that)</i>; responsible parenting; and nutrition). (Probe if these things were really new, or whether they already learned this during antenatal care) • Have you been able to change something following the home visit? (probe about hygiene practices; family planning (what contraceptive do you currently use or intend to use; perspective on spacing); physical exercise; breastfeeding <i>(exclusively until when?; obstacles to breastfeeding)</i>; responsible parenting; nutrition). Why where you (not) able to change? • Have you ever been referred back to hospital through a home visit? Why? If not, do you think you should have been referred? Why (not)? • How often do you go to the clinic for check-ups for you and you baby? Are you able to go to these check-ups? Were you motivated by the home visitor to go for follow-up visits to the clinic and to get vaccinations for your baby? • Did you feel respected by the home visitor? Why? Why not? (Probe for having enough time to discuss) What type of questions did you ask the home visitor? E.g. about what?
Impact	1f, 1g, 4g	<ul style="list-style-type: none"> • Have the home visits helped to keep your baby and yourself healthy? How? (probe for breastfeeding; immunization; reduction of harmful traditional practices such as wrapping baby, or use of oil and salt on umbilical cord) • Did the home visits help you with anything else? Did the home visits cause any problems? (unintended effects)
Future	4g, 5i-k	<ul style="list-style-type: none"> • What would you like to recommend in terms of home visits? Why? • Could social media play a role in supporting post-natal care? How?

C) In-depth Interview topic guide with mothers who did not have home visits

The purpose of this topic guide is to obtain the perspectives of mothers who have had (high risk) pregnancies on having to go to the clinic for post-natal care through in-depth interviews.

Please note, that this is a topic **GUIDE** and will be used as such, meaning that the questions proposed provide guidance only and that it will be important to adapt the questions during the interviews in such a way that they make sense to the respondents. In addition, the tools will be piloted immediately following the data collection training, and modified subsequently.

Further instruction for use: Prior to the interview, please ensure informed consent has been arranged by using the informed consent form. Then start the interview. Also make sure that the interview is conducted in a site that is comfortable for the respondents, and that their safety is safeguarded by amongst others not including their names in the interview notes, on the tapes, but on a separate sheet.

Area of inquiry	Link to questions in evaluation framework	Guiding Questions
Introduction		<p>Please obtain some background characteristics of the respondents in terms of</p> <ul style="list-style-type: none"> • Age • Household (husband, alive children, children who died, other people living in the home) • Brief obstetric history, including when children were born • Name(s) of clinic(s) for antenatal care, delivery, post-natal care; distance to clinics; way of transport to clinic(s)
Inclusion of and relevance for women and their families	2d, 2f, 2g, 4d, 4e, 4f	<ul style="list-style-type: none"> • Which type of women in Gaza are most in need of home visits just after giving birth? (probes: risk pregnancy; first pregnancy; lower socio-economic class;) Why them? • Do you know of women who received a home visit after delivery? If yes, why do you think they received such visits? What do you think of not having such a home visit yourself? • How many days after the delivery did you go for a post-natal check up to the clinic? Why then? Would you have been able to go earlier? • Who was with you when you went for the postnatal check-up? Was your mother or mother-in-law there? Were they able to ask questions? Did you get support from them afterwards? • Was your husband involved? Why (not)? Would you like him to be more involved?
Gained knowledge and practices	2g, 4b2-7, 4g, 4h	<ul style="list-style-type: none"> • What are things you learned from your visits to the clinic after delivery (postnatal) that you did not know or do before? (probe about hygiene; family planning; birth spacing; physical exercise; breastfeeding <i>(including the demonstration of breastfeeding; and tips and tricks around that)</i>; responsible parenting; and nutrition). • Have you been able to change something following the postnatal clinic visit? (probe about hygiene practices; family planning (what contraceptive do you currently use or intend to use; perspective on spacing); physical exercise; breastfeeding <i>(exclusively until when?; obstacles to breastfeeding)</i>; responsible parenting; nutrition). Why where you (not) able to change? • Having a new baby is beautiful, but can be a burden as well. Have you had difficulties to cope with this at times? Feelings of low mood? Extreme fatigue? Sleeplessness? Have you been able to discuss these feelings with the health workers in the clinic? How was that? What did you do? Did it help?

		<ul style="list-style-type: none"> How often do you need to go to the clinic for check-ups for you and your baby? Are you able to go to these check-ups? Who motivated you to go for follow-up visits to the clinic and to get vaccinations for your baby? Did the postnatal clinic visits help you with anything else? Or did it cause any problems? Did you feel respected during the post-natal visit in the clinic? Did you feel you got enough attention? Why? Why not?
Impact	1f	<ul style="list-style-type: none"> Have the postnatal clinic visits helped to keep your baby and yourself healthy? How? (probe for breastfeeding; immunization; reduction of harmful traditional practices such as wrapping baby, or use of oil and salt on umbilical cord)
Future	4g, 5i-k	<ul style="list-style-type: none"> What would you like to recommend in terms of post-natal care? Why? Do you have any suggestions on the use of social media (face book, WhatsApp etc) to support post-natal care?

D) In-depth Interview topic guide with fathers

The purpose of this topic guide is to obtain the perspectives of the fathers - whose wives have been part of the PNHV program - on the relevance, effectiveness, efficiency and impact of the home based visits through in-depth interviews. Please note that as mentioned in the evaluation sampling section, these fathers will **not** be the spouses of mothers interviewed, this because of ethics reasons.

Please note, that this is a topic **GUIDE** and will be used as such, meaning that the questions proposed provide guidance only and that it will be important to adapt the questions during the interviews/FGDs in such a way that they make sense to the respondents. In addition, the tools will be piloted immediately following the data collection training, and modified subsequently.

Further instruction for use: Prior to the FGD/interview, please ensure informed consent has been arranged by using the informed consent form (for FGD/interviews respectively). Then start the interview. Also make sure that the FGD/interview is conducted in a site that is comfortable for the respondents, and that their safety is safeguarded by amongst others not including their names in the interview notes, on the tapes, but on a separate sheet.

Area of inquiry	Link to questions in evaluation framework	Guiding Questions
Introduction		<p>Please obtain background characteristics of the respondents in terms of</p> <ul style="list-style-type: none"> Age Household composition (wife, number (including those who died) and age of children, other people living in the home) Name(s) of clinic used by his wife for antenatal care/delivery/post-natal care; distance to clinics; means of transport to the clinic
Inclusion of and relevance for women and their families	2d, 2f, 2g, 4d, 4e, 4f	<ul style="list-style-type: none"> When was the first time your wife received home visits following delivery (with 1st child, 2nd child etc...) How many home visits did she get (following each pregnancy)? Did she go for a second and third visit to the clinic? Was that feasible for her? Would it have been feasible for her to go for the first visit to the clinic as well? What was the benefit of the postnatal home visit according to you? What was the down side of the home visit?

		<ul style="list-style-type: none"> • Who was with your wife when the home visitor came? Were your mother or mother-in-law there? Did you notice any change in them after the home visit? • Were you yourself present during the home visit? Why (not)? Would you like to have been more involved? Why? • How useful were the home visits to your wife and to you? Why? • Which type of women in Gaza are most in need of home visits just after giving birth? (probes: risk pregnancy; first pregnancy; lower socio-economic class;) Why them? • Do you know why your wife was included in the post-natal home visiting program? How did you learn about this? What did you think about this?
Gained knowledge and practices	4b2-7, 4d, 2g	<ul style="list-style-type: none"> • What are things you (or your wife) learned from the home visitor that you did not know or do before? (probe about hygiene; family planning; birth spacing; physical exercise; breastfeeding (<i>including the demonstration of breastfeeding; and tips and tricks around that</i>); responsible parenting; and nutrition). (Probe if these things were really new, or whether they already learned this during antenatal care) • Have you (or your wife) been able to change something following the home visit? (probe about hygiene practices; family planning (what contraceptive do you currently use or intend to use; perspective on spacing); physical exercise; breastfeeding (<i>exclusively until when?</i>; <i>obstacles to breastfeeding</i>); responsible parenting; nutrition). Why were you (not) able to change? • Was your wife ever referred back to hospital through a home visit? Why? If not, should she have been referred? Why (not)? • Having a new baby is beautiful, but can be a burden as well. Has your wife have difficulties to cope with this at times? Feelings of low mood? Extreme fatigue? Sleeplessness? Has she been able to discuss these feelings with the home visitor? Did it help? Did she discuss it with you? • How often did your wife go to the clinic for check-ups for her and the baby? Did you go with her? Why (not)? • Were you motivated by the home visitor to interact more with your baby? If so, how and what interaction? • Did you feel respected by the home visitor? Why? Why not? (Probe for having enough time to discuss) What type of questions did you ask the home visitor? E.g. about what?
Impact	1f, 1g, 4g	<ul style="list-style-type: none"> • Have the home visits helped to keep your wife and your baby healthy? How? (probe for breastfeeding; immunization; reduction of harmful traditional practices such as wrapping baby, or use of oil and salt on umbilical cord) • Did the home visits help with anything else? Or cause any problems? (unintended effects)
Future	4g, 5i-k	<ul style="list-style-type: none"> • What would you like to recommend in terms of home visits? Why?

E) FGDs with midwives/nurses

The purpose of this topic guide is to obtain the perspectives of the midwives/nurses who have been involved in the PNHV programme on the relevance, effectiveness, efficiency, impact, sustainability and lessons learned of the home based visits through focus group discussions.

Please note, that this is a topic **GUIDE** and will be used as such, meaning that the questions proposed provide guidance only and that it will be important to adapt the questions during the interviews/FGDs in such a way that they make sense to the respondents. In addition, the tools will be piloted immediately following the data collection training, and modified subsequently.

Further instruction for use: Prior to the FGD/interview, please ensure informed consent has been arranged by using the informed consent form (for FGD/interviews respectively). Then start the interview. Also make sure that the FGD is conducted in a site that is comfortable for the respondents, and that their safety is safeguarded by amongst others not including their names in the interview notes, on the tapes, but on a separate sheet.

Area of inquiry	Link to questions in evaluation framework	Guiding Questions
Introduction		<p>Please obtain the following background characteristics of the respondents</p> <ul style="list-style-type: none"> Name, organization, position Professional background? (type of professional training; bachelors/2 yrs nursing?) Since when involved in the program?
Relevance and inclusion in the program	2d, 2e, 2f, 3d	<ul style="list-style-type: none"> How did you get involved in the program? Did you apply? Were you selected? How relevant is the PNHV program for addressing the need and demands of women who have had a risk pregnancy and just delivered a baby? Why? Can you give examples? And how relevant is the PNHV program for their infants? And for their spouses, and families? Why? Can you give examples? How relevant is the PNHV program for you as midwife/nurse? Why? Can you give examples?
Training and practices	3b-g, 4b1	<ul style="list-style-type: none"> What training did you receive as part of the PNHV program (days/number of trainings, content, teacher, quality)? What did you learn that you did not know before? (Please probe to get further insight) Can you show your HV-kit/bag? Who is responsible for maintaining the bag and substituting equipment? Are you always able to get equipment? Is all the equipment useful? E.g. do you use your hemoglobinometer? Is there equipment that you miss? (e.g. thermometer, timer/watch, iron tablets, antibiotics, eye ointment, glucometer?) How are you informed about new patients for the home visiting program? By who? On time? What challenges have you faced thereby? What are indications for you to refer a patient back to hospital? Are these clear to you? Where do you refer to? How? Do you feel comfortable on referring? What are the most important tasks during the home visit? Do you use check-lists during home visits? Can you show me what it looks like? How is information of patients filed? Do they have cards? Do you have a record book? Do you often face psychological problem with the mothers? Do you feel at ease to discuss these with them? Do you know how to help/refer them? To what extent are fathers and other members of the household involved? And how? What kind of monitoring/supervision do you receive? If so, how does this help you with your home visiting tasks? What are the biggest challenges that you change in relation to the post-natal home visiting program?
Effects of program	4a, 4h	<ul style="list-style-type: none"> What are according to you the main achievements of the program? (probe around timely detection and referral of post-natal complications; changed behaviour of mothers, fathers, and extended family in relation to hygiene, nutrition, exclusive breastfeeding, birth spacing, responsible parenting; physical exercise, timely detection of psychological problems; vaccination uptake) What do you consider as the main achievements? (Probe for increased contraceptive use; increased exclusive breastfeeding; increased immunization; changed social and traditional practices) What evidence (or anecdotal information) exists about those changes? What are unintended consequences of the post-natal home visiting program (if any)? Can you please elaborate? What has caused this?

Area of inquiry	Link to questions in evaluation framework	Guiding Questions
Impact	1a, 1b, 1f, 1g	<ul style="list-style-type: none"> In your opinion, has the home visits program contributed to decreased neonatal and or maternal morbidity? To decreased neonatal and or maternal mortality? Can you give examples? How do you know this change is related to the home visiting program? In your opinion, has the home visits program contributed to changed norms and values? Can you give examples? How do you know this change is related to the home visiting program?
Future	4g, 5i-k	<ul style="list-style-type: none"> Do you have any suggestions for the future of the program so that it could function without external support from i.e. UNICEF? (probe around including PNC into other activities or use of social media (facebook, whatsapp, etc) What key lessons have you learned based on the post-natal home visits? (probe why and what?) What would you improve/change? Why?

F) In-depth Interview topic guide with key stakeholders

The purpose of this topic guide is to obtain the perspectives of key stakeholders who have been involved in the PNHV programme on the relevance, effectiveness, efficiency and impact of the home based visits through in-depth interviews.

Please note, that this is a topic **GUIDE** and will be used as such, meaning that the questions proposed provide guidance only and that it will be important to adapt the questions during the interviews/FGDs in such a way that they make sense to the respondents. In addition, the tools will be piloted immediately following the data collection training, and modified subsequently.

Further instruction for use: Prior to the FGD/interview, please ensure informed consent has been arranged by using the informed consent form (for FGD/interviews respectively). Then start the interview. Also make sure that the interview is conducted in a site that is comfortable for the respondents, and that their safety is safeguarded by amongst others not including their names in the interview notes, on the tapes, but on a separate sheet.

Area of inquiry	Link to questions in evaluation framework	Guiding Questions
Introduction		<p>Please obtain the following background characteristics of the respondents</p> <ul style="list-style-type: none"> Name, position, organization Length of work in current position (if a short period only; previous position as well). Type of involvement with PNHV program
Relevance	2c, 2d, 2f, 2g, 4d, 4e, 4f	<ul style="list-style-type: none"> How is the PNHV in line with the Palestinian strategy regarding maternal and neonatal health and its priorities? Who are the women and children most at risk, that are included in the program? What focus does the program have on those most disadvantaged in terms of vulnerability and hard to reach? What geographical area is being covered by the

Area of inquiry	Link to questions in evaluation framework	Guiding Questions
		<p>program? Are there areas that should be included but are out of reach? What percentage of the total deliveries in your area is identified as high risk and included for PNHV?</p> <ul style="list-style-type: none"> How are issues of human rights and gender addressed in the PNHV program?
Efficiency	3b-g, 4b8	<ul style="list-style-type: none"> Is the program able to implement all the scheduled activities every year (number of midwives/nurses trained; number of home visits made; timeliness of home visits; home visiting equipment in order, etc? If yes, what contributes to that? If no, what are the challenges with the implementation? (Probe for timely receipt of funding, funding flows; collaboration mechanisms; influence of political unstable situation? What monitoring information is being collected by the program (distribution/substitution materials PNHV kits for home visitors; medical information of the patient; record book of home visitors; ...)? How is this information used to inform the program? What technical assistance has been received from UNICEF and other partners? What is the effect of this technical assistance? (Probe also for supportive supervision mechanisms)... With what other stakeholders was there collaboration? How frequent does this collaboration take place? What is the effect of this collaboration? Involvement of the communities and community leaders in this collaboration?
Effectiveness	4a, 4g, 4h	<ul style="list-style-type: none"> What are you most proud of in the program? (Probe for achievements around timely detection and referral of post-natal complications; changed behavior of mothers, fathers, and extended family in relation to hygiene, nutrition, exclusive breastfeeding, birth spacing, responsible parenting; physical exercise, timely detection of psychological problems; vaccination uptake) What do you consider as the main achievements? (Probe for increased contraceptive use; increased exclusive breastfeeding; increased immunization; changed social and traditional practices) What evidence (or anecdotal information) exists about those changes? What are the biggest challenges? What are unintended consequences of the post-natal home visiting program (if any)? Can you please elaborate? What has caused this?
Impact	1a, 1b, 1f, 1g	<ul style="list-style-type: none"> In your opinion, has the home visits program contributed to decreased neonatal and or maternal morbidity? To decreased neonatal and or maternal mortality? What is the evidence? How do you know this change is related to the home visiting program? In your opinion, has the home visits program contributed to changed norms and values? Can you give examples? How do you know this change is related to the home visiting program?
Sustainability	5a-h	<ul style="list-style-type: none"> Different models exist next to each other, what are the pro's and con's of the different approaches/models, why? Do you have any suggestions for the future of the program? (probe around issues related to sustainability; what model is most sustainable? What plans are there to integrate more attention for PNC into other activities? (i.e. in the standard training curriculum of midwives, nurses; within first hours after delivery?) What systems and regulations are in place for monitoring and follow up on high risk pregnancies and neonates, infants, mothers that are under high risk? (Probe around use of social media (face book, WhatsApp as other ways of communication)

Area of inquiry	Link to questions in evaluation framework	Guiding Questions
		<ul style="list-style-type: none"> • What alternative funding mechanisms exist? What possibilities are there to cover this from insurance mechanisms? • What plans are there to improve PNC for all women in Gaza, besides special attention for those most at risk? (Besides the current plans to improve post-natal care in the first few hours after delivery).
Lessons learned	5i-k	<ul style="list-style-type: none"> • What key lessons have you learned based on the post-natal home visits? (probe why and what?) • What would you improve/change? Why?

Annex 7 Informed Consent forms

Consent form for FGD

Informed Consent form for **Focus Group Discussions** with 1) *mothers who have delivered in the period 2011-2016 and have been in contact with the Postnatal Home Visiting programme*; and 2) *community health workers and mid-wives who have been trained through the programme*. (One copy for evaluation team; and a copy for each FGD respondent)

Read out loud to the participants:

Introduction

Hello, we are (names). We are from the Royal Tropical Institute in the Netherlands and Juzoor Palestine. We are trying to learn more about the Postnatal Home Visiting Programme in Gaza which is supported by UNICEF. The Royal Tropical Institute (KIT) and Juzoor have been contracted by UNICEF State of Palestine to evaluate the Postnatal Home Visiting Programme in Gaza. We would like to ask you to participate in a focus group discussion so that we can ask some questions around this.

Why is this evaluation done?

The Postnatal Home Visiting Programme in Gaza for the most vulnerable mothers and new-borns immediately in the first few weeks after delivery has been established in 2011. Through the programme midwives and community health workers have been trained on postnatal care and home-based child care, postnatal home visit kits have been provided, and home visits are being conducted for women who had high risk pregnancies and their new-borns/infants.

In order to understand what the programme has been able to achieve for these newborns, infants and their families in Gaza, and the challenges faced since its beginning, this evaluation is done. The results of the evaluation will help the Ministry of Health, UNRWA, UNICEF and other stakeholders on how to further improve activities for newborns, infants and their families.

What is done?

The evaluation team conducts interviews and focus group discussions with a range of different people, in the first place with mothers (and their family members) who have delivered in the period 2011-2016 and have been in contact with the Postnatal Home Visiting programme; community health workers and mid-wives who have been trained through the programme; other health professionals, programme managers, and policy makers. All respondents are asked to provide their perspectives on the successes and challenges of the programme, and why this is so.

Besides the interviews and focus group discussions, the evaluation team will also review a number of documents and data bases to complement the interviews and or focus groups.

Can participation harm me?

The group discussion may bring back emotional memories related to the pregnancy and delivery. If needed referral can be made to a counsellor following the interview. Your participation will be in this Focus Group Discussion only. However, perhaps you may feel that some questions are sensitive or embarrassing. You are free

to stop participating in the Focus Group Discussion at any time, or not to answer particular questions. Your participation in this Focus Group Discussion is completely voluntary. Not participating or stopping the Focus Group Discussion will not in any way affect your access to information and services or have any other consequence.

Can participation benefit me?

This evaluation does not help you directly but the results will help the Ministry of Health, UNRWA, UNICEF and other stakeholders to improve activities for newborns/infants, their mothers and their families.

Procedures including confidentiality

The Focus Group Discussion will take one to one and a half hour approximately. What will be said and written down will not be linked to your name during analysis and in final products. However, as we discuss this in a group, we cannot guarantee that no one will share the information outside this group. We would like to remind all participants to respect the privacy of your fellow participants and not repeat what is said in this focus group discussion to others.

We would also like you to know that there is no right or wrong answer, anything that you will be able to share is worthwhile.

Audio recordings?

If you agree, we would like to record the interview. The recording will be used to complement the notes taken during the interview. By taping the interview, we can thus better ensure that your perspective is reflected better in the evaluation. Thereby we will ensure that your contribution remains anonymously. The tape and notes (or transcripts) will also be destroyed as soon as the evaluation has been completed.

Will the results of the results of the evaluation be shared with me?

The evaluators will ask UNICEF to share the results of the evaluation with all those who participated in it and have indicated to be interested in receiving its results.

Consent

Do you have any questions that you would like to ask? We would be happy to answer them.

Are there any things you would like to know? If you do not want to take part in this interview, please feel free to tell us.

If you agree, could you sign a copy of this form. You can also get a copy to take home as it has our contact details on it, and you can read again what this focus group discussion is about.

DECLARATION: TO BE GIVEN IN WRITING BY THE RESPONDENT

Agreement respondent

I understand why I am being interviewed and I agree with participating in the Focus Group Discussion and to be recorded:

.....

Signature

Date:

Place:

If you have any questions or want to file a complaint about the evaluation you are welcome to contact:

If you have any questions or want to file a complaint about the consultancy you are welcome to contact:

Juzoor	Royal Tropical Institute (KIT)
For information (Juzoor): UmaiyeH Khammash Al-Bireh/ Al-Arkan St. Islamic Palestinian Bank Building, 3rd Floor P.O.Box 4207, Ramallah Telephone: +970-2-2414488 Fax: +970-2-2414484 www.juzoor.org	For information (KIT): Pam Baatsen, Senior Advisor p.baatsen@kit.nl KIT Development Policy & Practice T +31 (0)20 568 8432 Mauritskade 63 [1092 AD] P.O. Box 95001, 1090 HA Amsterdam The Netherlands www.kit.nl
UNICEF SoP	UNICEF Gaza
For complaints: Selena Bajraktarevic, PhD Chief Health and Nutrition UNICEF State of Palestine, Jerusalem Tel: +972 (0)2 5840461 Cell: +972 (0)54 778 7623 email: sbajraktarevic@unicef.org	Younis Awadallah < yawadallah@unicef.org >

Consent form for interview for women who have had (high risk) pregnancies in the period 2011 – 2016 and or their spouses

Informed Consent Forms (two copies needed per interviewee – one for evaluation team and one for interviewee)

Informed Consent form for **interviews** for women who have had (high risk) pregnancies in the period 2011 – 2016 and or their spouses
with those involved in the Postnatal Home Visiting Programme in Gaza

Read out loud to the interviewee:

Introduction

Hello, we are (names). We are from the Royal Tropical Institute in the Netherlands and Juzoor Palestine. We are trying to learn more about the Postnatal Home Visiting Programme in Gaza which is supported by UNICEF. The Royal Tropical Institute (KIT) and Juzoor have been contracted by UNICEF State of Palestine to evaluate the Postnatal Home Visiting Programme in Gaza. We would like to ask you to participate in an interview so that we can ask some questions around this.

Why is this evaluation done?

The Postnatal Home Visiting Programme in Gaza for the most vulnerable mothers and new-borns immediately in the first few weeks after delivery has been established in 2011. Through the programme midwives and community health workers have been trained on postnatal care and home-based child care, postnatal home visit kits have been provided, and home visits are being conducted for women who had high risk pregnancies and their newborns/infants.

In order to understand what the programme has been able to achieve for these newborns, infants and their families in Gaza, and the challenges faced since its beginning, this evaluation is done. The results of the evaluation will help the Ministry of Health, UNRWA, UNICEF and other stakeholders on how to further improve activities for newborns, infants and their families.

What will be done?

The evaluation team conducts interviews and focus group discussions with a range of different people, in the first place with mothers (and their family members) who have delivered in the period 2011-2016 and have been in contact with the Postnatal Home Visiting programme; community health workers and mid-wives who have been trained through the programme; other health professionals, programme managers, and policy makers. All respondents are asked to provide their perspectives on the successes and challenges of the programme, and why this is so.

Besides the interviews and focus group discussions, the evaluation team will also review a number of documents and data bases to complement the interviews and or focus groups.

Can participation harm me?

The interview may bring back emotional memories related to the pregnancy and delivery. If needed, referral can be made to a counsellor following the interview. Your participation is entirely on a voluntary basis and your

information will be kept confidential. You are free to ask the interviewer to stop the interview at any point in time or not to answer a particular question. Withdrawing from the interview will not in any way affect your reputation, access to services or have any other consequence.

Can participation benefit me?

This evaluation does not help you directly but the results will help the Ministry of Health, UNRWA, UNICEF and other stakeholders to improve activities for newborns/infants, their mothers and their families.

Audio recordings?

If you agree, we would like to record the interview. The recording will be used to complement the notes taken during the interview. By taping the interview, we can thus better ensure that your perspective is reflected better in the evaluation. Thereby we will ensure that your contribution remains anonymously. The tape and the notes (or transcript) of the interview will be destroyed as soon as the evaluation has been completed.

Will the results of the evaluation be shared with me?

The evaluators will ask UNICEF to share the results of the evaluation with all those who participated in it and have indicated to be interested in receiving its results.

Procedures including confidentiality

An experienced researcher will interview you. The interview will last approximately 45 minutes to one hour. What will be said and written down will not be linked to your name during analysis and in final products.

Consent

Do you have any questions that you would like to ask?

Are there any things you would like to be explained further?

If you do not want to take part in this interview you can refuse to give consent.

DECLARATION: TO BE GIVEN IN WRITING BY THE RESPONDENT

Agreement respondent

The purpose of the interview was explained to me and I agree to be interviewed and to be recorded:

Signature

Date:

If you have any questions or want to file a complaint about the consultancy you are welcome to contact:

Juzoor	Royal Tropical Institute (KIT)
<p>For information (Juzoor): For information (Juzoor): Umaiye Khammash Al-Bireh/ Al-Arkan St. Islamic Palestinian Bank Building, 3rd Floor P.O.Box 4207, Ramallah Telephone: +970-2-2414488 Fax: +970-2-2414484 www.juzoor.org</p>	<p>For information (KIT): Pam Baatsen, Senior Advisor KIT Health p.baatsen@kit.nl T +31 (0)20 568 8432 Mauritskade 63 [1092 AD] P.O. Box 95001, 1090 HA Amsterdam The Netherlands www.kit.nl</p>
UNICEF SoP	UNICEF Gaza
<p>For complaints:</p> <p>Selena Bajraktarevic, PhD Chief Health and Nutrition UNICEF State of Palestine, Jerusalem Tel: +972 (0)2 5840461 Cell: +972 (0)54 778 7623 email: sbajraktarevic@unicef.org</p>	<p>Younis Awadallah <yawadallah@unicef.org></p>

Consent form for interview for key stakeholders (Policy makers, UNICEF/UN, NGOs, and others (including health providers))

Informed Consent Forms (two copies needed per interviewee – one for evaluation team and one for interviewee)

Informed Consent form for **interviews** with key stakeholders (policy makers, UNICEF/UN, NGOs and others who have been (indirectly) involved in the Postnatal Home Visiting Programme in Gaza

Read out loud to the interviewee:

Introduction

Hello, we are (names). We are from the Royal Tropical Institute in the Netherlands and Juzoor Palestine. We are trying to learn more about the Postnatal Home Visiting Programme in Gaza which is supported by UNICEF. The Royal Tropical Institute (KIT) and Juzoor have been contracted by UNICEF State of Palestine to evaluate the Postnatal Home Visiting Programme in Gaza. We would like to ask you to participate in an interview so that we can ask some questions around this.

Why is this evaluation done?

The Postnatal Home Visiting Programme in Gaza for the most vulnerable mothers and new-borns immediately in the first few weeks after delivery has been established in 2011. Through the programme midwives and community health workers have been trained on postnatal care and home-based child care, postnatal home visit kits have been provided, and home visits are being conducted for women who had high risk pregnancies and their newborns/infants.

In order to understand what the programme has been able to achieve for these newborns, infants and their families in Gaza, and the challenges faced since its beginning, this evaluation is done. The results of the evaluation will help the Ministry of Health, UNRWA, UNICEF and other stakeholders on how to further improve activities for newborns, infants and their families.

What will be done?

The evaluation team conducts interviews and focus group discussions with a range of different people, in the first place with mothers (and their family members) who have delivered in the period 2011-2016 and have been in contact with the Postnatal Home Visiting programme; community health workers and mid-wives who have been trained through the programme; other health professionals, programme managers, and policy makers. All respondents are asked to provide their perspectives on the successes and challenges of the programme, and why this is so.

Besides the interviews and focus group discussions, the evaluation team will also review a number of documents and data bases to complement the interviews and or focus groups.

Can participation harm me?

Your participation is entirely on a voluntary basis and your information will be kept confidential. You are free to ask the interviewer to stop the interview at any point in time or not to answer a particular question. Withdrawing from the interview will not in any way affect your reputation, or have any other consequence.

Can participation benefit me?

This evaluation will not benefit you as a person, but the results are meant to assist the Ministry of Health, UNRWA, UNICEF and other stakeholders to improve activities for newborns/infants, their mothers and their families.

Audio recordings?

If you agree, we would like to record the interview. The recording will be used to complement the notes taken during the interview. By taping the interview, we can thus better ensure that your perspective is reflected better in the evaluation. Thereby we will ensure that your contribution remains anonymously. The tape and the notes (or transcript) of the interview will be destroyed as soon as the evaluation has been completed.

Will the results of the evaluation be shared with me?

The evaluators will ask UNICEF to share the results of the evaluation with all those who participated in it and have indicated to be interested in receiving its results.

Procedures including confidentiality

An experienced researcher will interview you. The interview will last approximately 45 minutes to one hour. What will be said and written down will not be linked to your name during analysis and in final products.

Consent

Do you have any questions that you would like to ask?

Are there any things you would like to be explained further?

If you do not want to take part in this interview you can refuse to give consent.

DECLARATION: TO BE GIVEN IN WRITING BY THE RESPONDENT

Agreement respondent

The purpose of the interview was explained to me and I agree to be interviewed and to be recorded:

Signature

Date:

If you have any questions or want to file a complaint about the consultancy you are welcome to contact:

Juzoor	Royal Tropical Institute (KIT)
<p>For information (Juzoor): For information (Juzoor): Umaiye Khammash Al-Bireh/ Al-Arkan St. Islamic Palestinian Bank Building, 3rd Floor P.O.Box 4207, Ramallah Telephone: +970-2-2414488 Fax: +970-2-2414484 www.juzoor.org</p>	<p>For information (KIT): Pam Baatsen, Senior Advisor KIT Health p.baatsen@kit.nl T +31 (0)20 568 8432 Mauritskade 63 [1092 AD] P.O. Box 95001, 1090 HA Amsterdam The Netherlands www.kit.nl</p>
UNICEF SoP	UNICEF Gaza
<p>For complaints:</p> <p>Selena Bajraktarevic, PhD Chief Health and Nutrition UNICEF State of Palestine, Jerusalem Tel: +972 (0)2 5840461 Cell: +972 (0)54 778 7623 email: sbajraktarevic@unicef.org</p>	<p>Younis Awadallah <yawadallah@unicef.org></p>

Annex 8 Overview stakeholders interviews

Name of interviewee		Position	Sector	Gender
1.	Azaa Qaoud	Supervisor of maternity health in PHC/MOH	Governmental	Female
2.	Dr Nahla Hillis	Director of Mother and child Health department in PHC/MOH	Governmental	Female
3.	Dr Sawsan Hammad	Director of Women Health and development department in PHC/MOH	Governmental	Female
4.	Lubna Sabbah	Health program coordinator at NECC	NGOs	Female
5.	Asmaa abu Hassan	Health program coordinator at NECC	NGOs	Females
6.	Jehan Al Aklouk	Projects Manager at UWHC	NGOs	Female
7.	Dr Jameel abu Fanounah	consultant on Obstetrics and Gynaecology at Al Awdah hospital- UWHC	NGOs	Male
8.	Fayza Al Sharif	Field Nursing Officer-UNRWA	United Nations	Female
9.	Dr Zohair El Khatib	Field Family Health Officer-UNRWA	United Nations	Male
10.	Itimad Abu Ward	Public Health officer of HRHR project- WHO	United Nations	Females
11.	Osaama Abu Eitaa	Head of UNFPA Gaza Sub-office	United Nations	Male
12.	Mariam Shaqoraa	Woman's affairs Director at RCS –Gaza/ Jabalia centre	NGOs	Female
13.	Dr Younis Awadallah	PNHV project Coordinator/ Health specialist	United Nations	Male
14.	Moeen Al Kariri	Head of Health Education and promotion department at MOH- Gaza	Governmental	Male
15.	Laila Al Masharfa	Nursing director for maternity in AL Shifaa hospital at MOH- Gaza office	Governmental	Female

Annex 9 Research Ethics Approval



Research Ethics Approval

22 January 2018

Pam Baatsen, MA
c/o UNICEF MENARO
Amman, Jordan

RE: Ethics Review Board findings for: *Evaluation of a Postnatal Home Visiting Program for neonates, infants and their families in Gaza, State of Palestine, over the period 2011 – 2016*

Dear Ms. Bassten,

Protocols for the protection of human subjects in the above study were assessed through an ethics review by HML Institutional Review Board on 10 – 22 January 2018.

This study's human subjects' protection protocols, as stated in the materials submitted, received **IRB approval**. Please inform this IRB if there are any changes to your human subject protection protocols.

Sincerely,

D. Michael Anderson, Ph.D., MPH
Chair & Human Subjects Protections Director, HML IRB

cc: Valentina Prosperi, Roumiana Gantcheva, Penelope Lantz, unicef@hmlirb.com

HML Institutional Review Board
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US Department of Health & Human Services, Office of Human Research Protections IRB #00001211

Annex 10 Assumptions of the Theory of Change

Assumption A1

While PNHV is a right for all delivered women, conducting post-natal home visits for women who have had high-risk pregnancies and prime para helps to effectively reach those most vulnerable to infant and maternal mortality and morbidity

Assumption A2

The postnatal period is an essential time for interventions to reduce infant and maternal morbidity and mortality and to start exclusive breastfeeding

Assumption A3

Women who have had high-risk pregnancies and prime para women face challenges to come to the health facility for a post-natal check up in the first 72 hours after the delivery for themselves and their new-borns

Assumption A4

The home visits allow to also provide health promotion around post-natal care to the spouses, mothers-in-law, mothers, sisters and others within the family to provide better support to the women who have had risk pregnancies

Assumption A5

Health promotion around post-natal care during antenatal care or postnatal care in the clinic is of lower quality than during post-natal home visits due to health facilities being over-crowded and shortness of staff

Assumption A6

An effective link can be established between the hospitals where delivery takes place and the primary health care system to facilitate timely home visits to women who have had risk pregnancies and to reach a harmonized approach among service providers to ensure provision of PNC

Assumption A7

The health system has limited financial and human resources and therefore home visits should only be made to those with the highest risk for maternal and neonatal morbidity and mortality

Assumption A8

Home visits should be done by skilled midwives and or nurses, and cannot be done by community health volunteers

Assumption A9

Well-educated women who have had risk pregnancies are in equal need of home visits than those less well-educated and of lower socio-economic class

Assumption A10

Monitoring data from the home visits by different entities are collected and collated and used to inform the program

Assumption A11

Post-natal care is included in the training curriculum of mid-wives but will be regularly updated with the newest insights.

Assumption A12

Stronger coordination among different service providers will ensure provision of evidence based interventions and a standardized package of PNC services