MFAT funded Pacific Maternal, Newborn and Child Health Programme

Review Report

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3-17-2017

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Executive Summary

The UNICEF Maternal, Neonatal and Child Health (MNCH) Programme supports 14 Pacific Island Countries and Territory (PICTs) with the aim of *"ensuring that pregnant women, mothers and children have equitable benefit from high impact interventions for accelerated improvement of neonatal, child and maternal survival, health and nutrition."* Since July 2013 up to the present, the New Zealand Ministry of Foreign Affairs and Trade (MFAT) has been the main donor, funding approximately 40% of UNICEF's MNCH programme in the PICTs. As the programme is in its final year, a programme review was commissioned to document achievements, challenges and lessons learned with the intent of informing the design, management and implementation of current and future MNCH activities. Primary stakeholders of the review are the Pacific governments that participate in the MNCH programme, UNICEF Pacific and MFAT.

The review was framed around key questions, as agreed between UNICEF Pacific and MFAT, and conducted over the period February 6th – 24th, 2017. Data sources included document review; key informant interviews; stakeholder consultation; and observations. Data sources were used in combination to triangulate information, probe areas requiring further clarification and deepen understanding, particularly as pertains to lessons and future programming. Field visits were conducted to Solomon Islands and Kiribati, which have been used as more detailed "case studies" for the review.

The review found that programme outcomes, defined in the proposal, had been "generalised" over time to the three main outcome areas: expanded programme of immunisation; nutrition and new-born health; and health systems strengthening (HSS). There were clear gaps in logic within the initial framework presented in the proposal which may have prompted a shift to a more utilitarian focus, outcome areas and results statements. In January 2017, a request to revise the results was made to MFAT with the intent of making these more concise, measurable and achievable. Explanations provided for adjustments to the results are reasonable, if not late coming, as some results were considered "constrained" and difficult to achieve as early as year 1.

Given the lack of a logical framework, combined with limited knowledge management, it was difficult to track progress of the programme over time or understand the underlying causal factors that have facilitated or impeded this. That said, UNICEF has undoubtedly contributed to improved MNCH with notable achievements:

- EPI average coverage by PICT is 84%, 87% and 79% for MCV1, Polio 3 and Hepatitis B respectively.
- New vaccines including pneumococcal conjugate vaccine (PCV), rotavirus vaccine (RV) and human papillomavirus vaccine (HPV) have been introduced in several PICTs, underpinned by MFAT support.
- Initiation of a range of MNCH activities aimed at improving the enabling environment and access to high impact nutrition interventions and essential new born care, at health facility and community level.
- Provision of micronutrient products and other essential supplies and equipment for MNCH in tier one countries.

The combination of UNICEF international technical and national contextual experts has contributed to the achievement of programme results however this support has not always been consistent due to staff turnover and vacancies in the region. Flexibility has also facilitated achievements, particularly in contexts where there is limited health system responsiveness. While UNICEF maintains an 'on plan, on budget' approach in tier one countries, it has opted to remain partially 'off system' given poor absorptive capacity and the need to circumvent health system bottlenecks.

The context also dictates the need for flexibility as the Pacific region is prone to frequent natural disasters and disease outbreaks. This has affected the achievement of MFAT targets and contributes to the fragility of achievements. While emergency response is not funded under MFAT, its flexible approach does allow the programme latitude to respond (within its limited resource envelope). A

contraction of donor funding in some PICTs and introduction of other reproductive, maternal, neonatal, child and adolescent health (RMNCAH) programmes, has required the MNCH programme to adjust its scope and focus, to ensure complementarity with these broader initiatives and address gaps where these have emerged.

Recommendations have been formulated based upon findings from the review and lessons emerging from programming to date. These suggest that programmatic and operational flexibility should be maintained but needs to be underpinned by coherent results logic, with health systems strengthening (HSS) as an over-arching strategy. The remainder of the MFAT grant period should be used to consolidate activities and lay a foundation for UNICEF's new country programme.

Future MFAT programming should be conceptualised using UNICEF's strategic framework for the period 2018-2022, which addresses intervention across the socio-ecological model, from the individual through to the institutional, in selected countries. Technical assistance should be more focused, with greater attention to sub-national levels in selected countries to yield greater impact; this would include more attention to integrated outreach, supportive supervision and on-the-job training, and a move away from a 'trickle down' approach with training and commodities as entry points at national level. Intervention, should be underpinned by bottleneck analysis, with support from UNICEF's social policy section. In recognition that immunization coverage remains fragile in PICTs, the review also recommends continued support for improving quality and coverage of routine vaccinations. The Vaccine Independence Initiative (VII) offers an important service to PICTs, enabling them to procure quality vaccines, supplies and cold chain equipment at an affordable price and effectively improving vaccines security. This initiative is the backbone to further improving coverage in PICTs and should continue.

Acronyms

BMS	Breastmilk substitutes
CBNMC	Community-based maternal and neonatal care
CICH	Centre for International Child Health
DFAT	Australian Department of Foreign Affairs and Trade
EENC	Early essential new-born care
EmONC	Emergency obstetric and new-born care
EPI	Expanded Programme on Immunisation
FSM	Federated States of Micronesia
GAVI	Global Alliance for Vaccines Initiative
GDP	Gross domestic product
HMIS	Health management information system
HPV	Human papillomavirus
HSS	Health systems strengthening
IFA	Iron folate
IMCI	Integrated management of childhood illness
KII	Key informant interview
LMIC	Lower middle income country
MBFHI	Mother-baby friendly hospital initiative
MFAT	Ministry of Foreign Affairs and Trade
MHMS	Ministry of Health and Medical Services
MIYCN	Maternal, infant and young child nutrition
MNCH	Maternal, neonatal and child health
MNP	Micro-nutrient powders
MR	Measles-rubella
NRH	National Referral Hospital
NZD	New Zealand dollars
PCV	Pneumococcal conjugate vaccine
PICs	Pacific island countries
PICTs	Pacific island countries and territories
RED	Reaching Every District
RMI	Republic of the Marshall Islands
RMNCAH	Reproductive, maternal, newborn, child and adolescent health
RV	Rota-virus
SAM	Severe acute malnutrition
TOR	Terms of reference
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VII	Vaccine Independence Initiative
WHO	World Health Organisation

1. Introduction

The UNICEF Maternal, Neonatal and Child Health (MNCH) Programme supports 14 Pacific Island Countries and Territory (PICTs) with the aim of *"ensuring that pregnant women, mothers and children have equitable benefit from high impact interventions for accelerated improvement of neonatal, child and maternal survival, health and nutrition."* Since July 2013 up to the present, the New Zealand Ministry of Foreign Affairs and Trade (MFAT) has been the main donor, funding approximately 40% of UNICEF's MNCH programme in the PICTs, and will have contributed NZD $5,999,915 to this for the period 2013-2017 (as per the agreed budget).

The programme has three main strategic areas of focus and seven intended results (Box 1) to be achieved by the end of programme in December, 2017.

- Expanded Programme on Immunisation (EPI);
- Improved nutrition and new-born health; and
- Improved health systems.

Box 1: MFAT MNCH intended programme results

- By 2017, 260,000 children under five in 17 PICTs are free from polio, measles and hepatitis B infection.
- By 2017, 30,000 children under one in 7 Pacific Island Countries (PICs) (Solomon Islands, Vanuatu, Samoa, Kiribati, Palau, Federated States of Micronesia (FSM) and the Republic of the Marshall Islands (RMI)) are protected against vaccine preventable diseases at all times and at least 3 PICs have introduced new vaccines (pneumococcal and rota viral vaccines) and 2 have introduced rubella vaccine.
- By 2017, malnutrition, especially stunting will be prevented and reduced in children under 2yrs in at least 3 (PICTs - Solomon Islands, Vanuatu, Nauru)
- By 2017, children and women, in selected areas of at least seven countries benefit from targeted programmes to prevent micronutrient deficiencies (Fiji, FSM, Kiribati, Nauru, RMI, Solomon Islands, and Vanuatu)
- By 2017, all health facilities in five selected PICs have enhanced pregnancy outcomes and reduced maternal and new-born illness and deaths (Solomon Islands, Vanuatu, Kiribati, RMI, FSM, Nauru and Fiji)
- By 2017, 62 hospitals in 14 PICs are declared mother-baby friendly
- By 2017, 120,000 children under five (80%) in seven PICs (Solomon Islands, Vanuatu, Samoa, Kiribati, Palau, FSM and RMI) receive quality of clinical service for pneumonia (proper antibiotic and diarrhoea (new ORS and zinc tablet)

2. Review

2.1 Purpose

As the programme is in its final year, a programme review was commissioned to document the current situation of MNCH in the Pacific and note achievements, challenges and lessons learned from the programme between 2013 and 2016. The programme review findings are to inform the design, management and implementation of the current and any future activities that contribute to improving MNCH in the Pacific. The generated information will inform MFAT's future funding decisions.

2.2 Objectives

The review objective is to understand what worked well to inform scale up and/or replication of successful elements of the programme. As such the primary stakeholders of the review are the Pacific governments that participated in the MNCH programme, UNICEF Pacific and MFAT. Specifically, the review will seek to understand:

- What worked well?
- What didn't work well?

- What was achieved with this investment?
- What results have been/are likely to be sustained?

2.3 Scope

The review covers all MNCH components implemented by UNICEF with respective PICT governments and partners covering the period 2013 to 2016. MNCH activities are understood as including immunization, supply chain and procurement, maternal and newborn health, nutrition, and health systems strengthening. While it was subsequently decided to focus on "tier one" countries to better target resources, the review has tried to maintain a broader regional focus, where data was available. Under the tier system (Box 2), countries are grouped according to overall human development status and progress on key child rights indicators. Solomon Islands and Kiribati, both tier one countries, have served as case studies for the review; as such, all methods have been applied and greater contextual and programmatic detail availed.

Box 2: UNICEF Pacific country tiers

- Tier one –least developed countries Kiribati, Solomon Islands, and Vanuatu (Kiribati subsequently achieved lower middle income status in 2015). Solomon Islands and Vanuatu are at particularly high risk of natural hazards and Kiribati is directly affected by climate change and rising sea levels.
- Tier two countries – lower middle income countries of Samoa (re-classified as middle income in 2014) and Tuvalu and middle income countries Fiji, Marshall Islands, Micronesia and Nauru, where disparities within countries remain high, particularly for children living on remote outer islands.
- Tier three countries – middle income countries of Palau and Tonga, the Cook Islands and Niue and the New Zealand territory of Tokelau, where there is stronger performance on child development indicators, albeit with some capacity gaps (particularly in micro-states).

3. Methodology

3.1 Review framework

In line with the terms of reference (TOR), the review was framed around a set of questions.

- To what extent is the programme thrust (approach) still valid and the programme is considered to be relevant and useful by partners?
- Are there any critical emerging issues that were not within the scope of the programme?
- Does the results framework provide an appropriate basis to support the achievement of identified results?
- What output targets were achieved as a result of the programme? To what extent will/have these achievements contributed to the programme outcomes?
- What are the major factors that influenced the achievement or non-achievement of the programme outputs?
- Are there any unexpected results of the programme either positive or negative that had not been planned for?
- To what extent have programme activities been embedded in health systems? What factors are influencing this?
- To what extent have gender, disability and environmental concerns been taken into consideration during the programme? How can these be better addressed in future?
- What investments have been made by other actors in the MNCH space during the course of the Programme and to what extent has there been complementarity, coordination or duplication?
- What are the lessons learned and recommendations for future consideration? What could be the recommended focus areas for the future programme to make the biggest impact on maternal, newborn and child health in alignment with national priorities of the Governments?

3.2 Data collection methods

The review used primary and secondary data to inform the questions. To facilitate data collection, country visits were conducted by the consultant to Fiji (Feb 6th-8th ; Feb 21st-24th); Kiribati (Feb 9th-13th); and Solomon Islands (Feb 13th-21st). Data sources included:

- Secondary data (over 30 documents, mainly generated through UNICEF)
- Key informant interviews (KIIs) and stakeholder consultation (13 UN – mainly UNICEF; two MFAT; 23 government managers and health workers, and one NGO partner)
- Observations (six and four health facility visits in Solomon Islands and Kiribati, one community discussion in Kiribati)

Data methods and sources of information by review question are outlined in Annex 1 while the list of documentary sources and people consulted are contained in Annexes 2 and 3 respectively. Data sources were used in combination to triangulate information, probe areas requiring further clarification and deepen understanding, particularly as pertains to lessons and future programming. Geographic focus of data collection is outlined in Box 3.

Box 3: Geographic focus of data collection

- Document review – *all PICTS*
- KIIs with UNICEF Pacific and MFAT – *all PICTS*
- Stakeholder consultation – *Solomon Islands and Kiribati*
- Observations – *Solomon Islands and Kiribati*

3.3 Limitations

The review faced some limitations as follows:

- Very little baseline data was available from which to benchmark progress of performance indicators;
- It is difficult to infer findings from the two country visits to the other PICTs given variation in context, capacities and connections (e.g. other actors working on MNCH and HSS);
- High turnover of UNICEF staff has limited knowledge management (while the consultant was provided with many documents, it was sometimes difficult to determine their relevance to the review);
- The review has largely relied upon UNICEF data sources, which could not be triangulated through other sources (given poor national monitoring systems and lack of access to these).
- Planned results are high level therefore it is difficult to assess performance against these.
- UNICEF staff served as the interpreters throughout all of the provincial field work. While the reviewer felt UNICEF's staff worked to be impartial, the degree to which key informants and FGD participants in the field modified their responses as a result of the presence of UNICEF staff is unknown. All participants were requested to speak open and honestly and were told that the purpose of the review was to learn about what worked well and not so well to inform future programming. UNICEF staff presence was not observed to have any significant impact on participants' willingness to speak openly about their experiences or perceptions.

4. Findings

Findings are presented by review question. These have been re-arranged from the TOR to facilitate flow of narration, starting with the results framework, moving to achievements and then considering more foundational questions in relation to the approach, unforeseen consequences, and contextual factors.

Does the results framework provide an appropriate basis to support the achievement of identified results?

UNICEF reports against the seven result areas stipulated in the contribution agreement and has done so for three consecutive years. In January, 2017, a request to revise the results was made to MFAT with the intent of making these more concise, measurable and achievable. [1] These are presented in Table 1. Explanations provided for adjustments to the results are reasonable, if not late coming in the programme. Given the late nature of the request for adjustments to the results, UNICEF and MFAT have agreed that UNICEF will continue to report against the seven result areas defined in the contribution agreement throughout the life of this grant. UNICEF is encouraged to explain deviations from result areas and additional achievements. A review of the three annual reports noted that some of the results were considered "constrained" and difficult to achieve as early as year 1.

Programme outcomes, defined in the proposal are not the same as in the contribution agreement.[2] The programme outcome in the proposal (which is stated as the programme goal in the contribution agreement) was for pregnant women, mothers and children to equitably benefit from high impact interventions for accelerated improvement of neonatal, child and maternal survival, health and nutrition. Three intermediate and six immediate outcomes were also defined in the proposal (the results framework from the proposal is included in Annex 4 for reference). Strategic areas have been used in place of these, as per the contractual agreement between UNICEF and MFAT, and align with the seven results, with HSS most closely associated with result seven.[3] Within this framework HSS is largely inferred, it is not explicit.

> *"Improving health systems goes beyond proper antibiotics and provision of new ORS and zinc tablets. Outputs 1-6 are also measuring the efficacy of the health system."*[4]

There were clear gaps in logic within the initial framework presented in the proposal. It was overly complex and very detailed. It may have prompted a shift to a more utilitarian focus on the contribution agreement's results statements. The logical framework, or theory of change, for the programme has not been used to report or plan against (the overall outcome is mentioned only in the year 1 report and the intermediate and immediate outcomes are not referred to at all).

Table 1: Current and proposed revisions to the results statements

	Current	Proposed	Explanation
Result 1	By 2017, 260,000 children under-five in 14 PICs are free from polio, measles and hepatitis B infection.	By the end of 2017, at least 80% of surviving infants (under 1) in 14 Pacific Island Countries (PICs) are vaccinated against polio, measles and hepatitis B infection.	Percentages are more accurate as population figures change over time. UNICEF Pacific covers only 14 countries "Being free from polio, measles and hepatitis B infection" is not measurable except for polio which has not been observed in the Pacific for some time. However, measles and hepatitis B infection can occur. What is measurable is the number of children vaccinated.

[1] Ibid.

[2] UNICEF and MFAT, 2013. Contribution Arrangement between MFAT and UNICEF Concerning Support for UNICEF-Supported Pacific MNCH Programme, Annex A, page 9. The contract has the three thematic or general outcomes EPI, Improved Nutrition and Newborn Health, and Improved Health systems.

[3] UNICEF presentation, January 2017. Proposed Revisions for the Programme Outcome Indicators. UNICEF and New Zealand Ministry of Foreign Affairs and Trade High Level Committee Meeting, Suva, Fiji.

[4] Ibid.

Result 2	By 2017, 30,000 children under one in seven PICs (FSM, Kiribati, Palau, RMI, Samoa, Solomon Islands and Vanuatu) are protected against vaccine-preventable diseases at all times and at least three PICs have introduced new vaccines (pneumococcal and rotavirus vaccines) and two have introduced rubella vaccines.	By the end of 2017, at least three PICs have introduced new vaccines (pneumococcal, rotavirus and human papilloma vaccines) and 2 have introduced rubella vaccines.	"Protected against vaccine-preventable diseases at all times" is not a measurable indicator. As Output 1 already includes coverage indicators, this output statement can be confined to new vaccines introduction (removing the coverage indicator). Human papilloma virus is also another new vaccine recommended by WHO.
Result 3	By 2017, malnutrition especially stunting will be prevented and reduced in children under 2 years in at least 3 Pacific Island countries (Solomon Islands, Vanuatu, Nauru)	By the end of 2017, at least 3 PICs (Solomon Islands, Vanuatu, Kiribati) adopt evidence based interventions to prevent and reduce malnutrition, especially stunting in children under 2 years.	Replacement of Nauru with Kiribati: Kiribati, along with Solomon Islands, Vanuatu are addressing malnutrition as part of the national strategy through the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) and have integrated evidence based nutrition interventions in their national business operational plans. Nauru is yet to adopt a comprehensive approach.
Result 4	By 2017, children and women in select areas of at least seven countries benefit from targeted programmes to prevent micronutrient deficiencies (micro-nutrient powders (MNP), IFA, vitamin A, deworming in Fiji, FSM, Nauru, RMI, Solomon Islands, Vanuatu)	By the end of 2017, at least six countries implement targeted programmes to prevent micronutrient deficiencies (Fiji, FSM, Kiribati, RMI, Solomon Islands and Vanuatu)	Based on available evidence in six countries, Fiji, FSM, Kiribati, RMI, Solomon Islands and Vanuatu where micronutrient deficiencies are public health problems, countries have requested UNICEF for support. Nauru does not have data on existing micronutrient deficiencies.
Result 5	By 2017, all health facilities in five select PICs have enhanced pregnancy outcomes and reduced maternal and newborn illness & deaths (Solomon Islands, Vanuatu, Kiribati, FSM, Nauru, Fiji, RMI)	By the end of 2017, three select PICs have strengthened pregnancy and newborn strategies to enhance pregnancy outcomes and reduced maternal and newborn illness and deaths (Solomon Islands, Vanuatu, Kiribati)	MHMS in Solomon Islands, Vanuatu and Kiribati have adopted RMNCAH as part of the national strategy and have integrated this within their national business operational plans. Other countries are yet to adopt a comprehensive and integrated RMNCAH approach.
Result 6	By 2017, 62 hospitals in 14 PICTs are declared 'Mother Baby Friendly'	By the end of 2017, at least 21 hospitals in six countries are supported to strengthen institutionalize 'Mother Baby Friendly Hospital Initiative' (Solomon Islands, Kiribati, Vanuatu, FSM, RMI, Nauru)	Reduce target to 21 hospitals (including those that are already accredited but do not implement all of the criteria and new hospitals yet to be certified) given that there are several steps which are process intensive.

Result 7	By 2017, 120,000 children under five (80%) in seven PICs (Solomon Islands, Vanuatu, Samoa, Kiribati, Palau, FSM and RMI) receive quality clinical service for pneumonia (proper antibiotic) and diarrhoea (new ORS and zinc tablets)	By the end of 2017, at least three PICs (Solomon Islands, Vanuatu, and Kiribati) implement strategies for the integrated management of childhood illness (IMCH), (pneumonia and diarrhoea)	The measurement of the current indicator cannot be ascertained from DHIS information, which is still weak in Pacific countries. The revised output focuses on service provision for integrated management of childhood illness (IMCI) – a protocol for managing childhood pneumonia and diarrhoea among others. The choice of three PICs is to support implementation of the national RMNCAH strategies already existing in these countries.

What output targets were achieved as a result of the programme? To what extent will/have these achievements contributed to the programme outcomes?

Given the lack of utilization of a logical framework, combined with limited knowledge management, it is difficult to track progress of the programme over time (except for results 1 and 2) or understand the underlying causal factors that have facilitated or impeded progress. . Annual reports are packed with activities but the "line of sight" is sometimes unclear between these and the programme outcomes. This question has therefore largely relied upon review of progress reported by UNICEF as well as interviews and observations in the Solomon Islands and Kiribati. Outputs are presented by original result in keeping with progress reporting.

Overall, results are fragile as tier one health systems have not demonstrated responsiveness or resilience.

Each result area has a different configuration of countries in terms of geographic focus, as originally envisaged in the proposal and reflected in results statements, however it is understood by the reviewer that resources have focused on tier one countries (this is also reflected in the proposed revisions to the results statements). As such, it has been difficult to ascertain if any intervention "exposure" has occurred in other PICTs, beyond what has been presented by UNICEF.

Result 1: By 2017, 260,000 children under-five in 14 PICs are free from polio, measles and hepatitis B infection.

Targets under this result area are on track due to consistent EPI support by UNICEF over the course of the MFAT grant as, without this, coverage would drop. The status of vaccine coverage for polio, measles and hepatitis B are highlighted in Box 4 while Annex 5 provides coverage estimates per country.

The average coverage by country is 84%, 87% and 79% for MCV1, Polio 3 and Hepatitis B respectively. The incremental costs of increasing coverage are substantial due to the additional logistical and tactical requirements of reaching and maintaining coverage of remote populations on the outer islands for example. UNICEF considers it is feasible to maintain a coverage rate of 80% but increasing this requires specialised skills and health systems capacities, which are not in place in all PICTS, particularly tier one countries.[5] As noted by the UNICEF procurement specialist, EPI is like "riding a bicycle".

The quality of the vaccine chain has improved, as have the integrity of vaccines (due to improved handling and storage), particularly in tier one countries where UNICEF has EPI officers based. In the Solomon Islands for example, UNICEF has supported the development and printing of the National Vaccine Cold Chain Policy, the first of its kind in the country. Similar guidance exists in other tier one countries, supported through UNICEF.

Box 4: Status of vaccine coverage

As reported through UNICEF,

- **MCV1** estimated coverage range is between 99% in the Cook Islands and 67% in Tonga, and reached an estimated 54,182 children during the reporting period (April 2015 to March 2016). Tier one countries have an estimated coverage of 92% in Solomon Islands, 84% in Kiribati and 84% in Vanuatu.
- **Polio 3** coverage range is between 99% in the Cook Islands and 61% in Samoa, and reached an estimated 56,582 children during the reporting period (April 2015 to March 2016). Tier one countries have an estimated coverage of 92% in Solomon Islands, 76% in Kiribati and 65% in Vanuatu.
- **Hepatitis B** birth dose range is between 99% in the Cook Islands and 65% in the Solomon Islands, and reached an estimated 49,996 children during the reporting period (April 2015 to March 2016). Remaining tier one countries have an estimated coverage of 80% in Vanuatu and 96% in Kiribati.

More detailed information on performance coverage is provided in Annex 5.

Source: UNICEF Pacific office, Suva, Fiji

Despite progress, there remain gaps in immunization, with noted "urban patches" in Honiara, Solomon Islands, for example, due to internal migration patterns while in Kiribati patches are more related to the outer islands. UNICEF has introduced 'RED' - reaching every district – as part of micro-planning, supported by UNICEF EPI officers. Reporting has improved however there remain some doubts about vaccination coverage rates in some contexts.[6] With measles and polio in particular, outbreaks pose an ongoing threat in the region as coverage levels are not adequate to ensure that countries remain polio-free and measles-free in the event of disease importation.[7]

Result 2: By 2017, 30,000 children under one in seven PICs (FSM, Kiribati, Palau, RMI, Samoa, Solomon Islands and Vanuatu) are protected against vaccine-preventable diseases at all times and at least three PICs have introduced new vaccines (pneumococcal and rotavirus vaccines) and 2 have introduced rubella vaccines.

Achievements under this result have been underpinned by MFAT support (e.g. financing of technical assistance) while new vaccines have been financed through other sources of funding. Four countries - Fiji, FSM, Palau and the RMI - have introduced all three of the new life-saving vaccines, pneumococcal conjugate vaccine (PCV), rotavirus vaccine (RV) and human papillomavirus vaccine (HPV). In addition,

[5] Finding also noted in Tyson S. and J. Clements, 2016. Strengthening Development Partner Support to Immunisation Programs in the Pacific Strategic Review, Mott MacDonald.

[6] As noted in: Trip Report, Wendy Erasmus, Solomon Islands December 6-9, 2016, Development Partners Coordination Group Meeting (DPCG) December 7th, 2016. This concern was more in relation to coverage rates (not accuracy) due to time lag in data availability (and reliance on catch up campaigns to boost coverage.

[7] Tyson S. and J. Clements, 2016. Strengthening Development Partner Support to Immunisation Programs in the Pacific Strategic Review, Mott MacDonald.

UNICEF has led the OPV switch in five countries. This entailed the globally coordinated switch from tOPV to bOPV.

Table 2 provides an overview of the new vaccine initiative by country. Introduction remains partial (in some instances as pilot only) and fragile as currently tier one governments do not provide domestic financing for these vaccines. In the Solomon Islands, the pilot of HPV in two provinces in 2015, integrated with the RED training, will be scaled up nationwide with Global Alliance for Vaccines Initiative (GAVI) support.

Table 2: Status of new vaccines introduction

Countries	PCV	RV	HPV
Cook Islands			2015
Fiji			
Kiribati	2013-14	2015	
RMI			
FSM			
Nauru			
Niue			
Palau			
Samoa			
Solomon Islands	2015	Planning for 2018	Pilot (2015)
Tonga			
Tuvalu			
Vanuatu			2017 (Pilot)

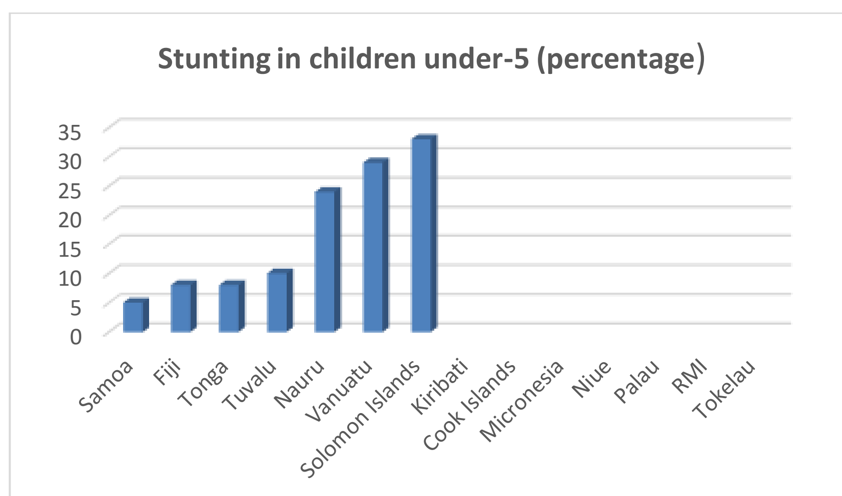
Source: UNICEF third annual progress report

Result 3: By 2017, malnutrition especially stunting will be prevented and reduced in children under 2 years in at least 3 Pacific Island countries (Solomon Islands, Vanuatu, Nauru)

Despite UNICEF efforts to address stunting and other forms of malnutrition, a systematic and consistent approach to detecting these conditions is not in place in tier one countries. In general, only children who look undernourished are assessed and stunting is not a visible condition. Targets are difficult to quantify, as data collection through national routine health systems and its quality have plagued analysis of

malnutrition trends. As noted by UNICEF, in several countries UNICEF, the MHMS and partners are operating in an 'information vacuum'. At present, only seven countries in the PICTs have stunting data (Figure 1).

Figure 1: Stunting in children under five in the PICTs



Source: UNICEF Strategy Note 2018-2022

UNICEF has supported a range of activities aimed at improving the enabling environment and access to high impact nutrition interventions at health facility and community level. These included but are not limited to:

Field note: In both Kiribati and Solomon Islands treatment for SAM is done in respective national referral hospitals. Health workers have been trained on SAM but have not developed guidelines for sub-national level and front line health facilities. RUTF is used at the National Referral Hospital in the Solomon Islands (300 children were treated in 2016 with 20% mortality). In Kiribati, it was in the central warehouse however it was unclear how it was being distributed or used.

- In tier one countries, height boards and scales have been provided by UNICEF, but not in adequate numbers for all health facilities. Kiribati estimates that 41% of health facilities have this equipment while no estimate was available for the Solomon Islands. About half of the health facilities visited as part of the review (Solomon Islands and Kiribati) did not have this equipment. The rationale for UNICEF procurement includes preferential rates for high quality equipment however resources are not enough to meet the requirements of all health facilities.
- Training for the treatment of severe acute (SAM) malnutrition has been introduced as have ready-to-use therapeutic (RUTF) commodities; training on nutrition in emergencies has also been done with several PICTs.
- Community-based maternal, infant and young child health and nutrition activities have been introduced, through UNICEF in partnership with the MHMS in Kiribati and World Vision International in the Solomon Islands (previous to this partnership, UNICEF introduced community-based interventions through the MHMS in Solomon Islands however these have not been sustained). In Kiribati, UNICEF and the MHMS has developed a similar programme by engaging youth health volunteers. This entailed training of 1,560 volunteers however, per the MHMS, only 120 remain active in their communities.[8]

While not all activities have been funded under MFAT (notably SAM and nutrition in emergencies), these compete for attention and resources with interventions focused on stunting (both within UNICEF

[8] Kiribati MHMS, 2017. Briefing for the Review of the New Zealand Ministry of Foreign Affairs and Trade (MFAT) MNCH-supported programme (power point presentation).

as well as with counterparts in government). An emphasis on emergency may also reinforce the notion that malnutrition is not a 'normal' event in these contexts.

Result 4: By 2017, children and women in select areas of at least seven countries benefit from targeted programmes to prevent micronutrient deficiencies (MNP, IFA, vitamin A, deworming in Fiji, FSM, Nauru, RMI, Solomon Islands, Vanuatu)

UNICEF facilitates procurement of micronutrient commodities in selected PICTs. The field visits to Kiribati and Solomon Islands confirmed that these commodities are available at the central warehouse level. However, both countries still have challenges with stock outs (of essential medicines), particularly at peripheral levels, which impact availability of micronutrient commodities. Tracking of indicators (e.g. children receiving Vitamin A and de-worming) in national health management information systems has been supported in Fiji, Solomon Islands, Kiribati, Vanuatu. UNICEF has also supported the updating of guidelines (reported in FSM) and advocated for the inclusion of nutrition supplies in national health budgets in Fiji, Solomon Islands, RMI, FSM, Vanuatu. In tier one countries, UNICEF supports the piloting of MNPs in emergencies. For example, these were distributed in areas of Honiara and Guadalcanal as part of the flood response in 2014 while in Kiribati, these are being piloted on one of the outer islands, Beru.

Field note: In Kiribati, the MHMS estimates coverage of Vitamin A and deworming to children under five at more than 60% for 2016. In Solomon Islands, this is estimated by UNICEF at 50% (Demographic and Health Survey, 2009). While it could be higher than this, it is not being tracked at provincial level through the health management information system (HMIS).

Result 5: By 2017, all health facilities in five select PICs have enhanced pregnancy outcomes and reduced maternal and newborn illness and deaths (Solomon Islands, Vanuatu, Kiribati, FSM, Nauru, Fiji, RMI)

Targets have not been set for this result area and baselines not included in the original proposal. That said, UNICEF has put significant effort into improving pregnancy and newborn outcomes. Equipment has been provided in tier one countries, including delivery beds, neo-natal warmers and examination lights. UNICEF provides systematic and strategic support to early essential newborn care (EENC), supported by a comprehensive newborn care situation analysis and roadmap.9 This has also included installation and setup of Paediatric Hospital Reporting Program v 10.1 together with delivery of two desktop computers for the National Referral Hospital (NRH) nursery and paediatric ward for data collection. Two years of data collection is now almost complete, providing more detailed information on case management outcomes at NRH to be used for death audits.10 UNICEF partnered with the Centre for International Child Health (CICH) in the Solomon Islands. Technical support has also been provided by UNICEF directly to other tier one countries. This has included costing of interventions in the country business operating plans (e.g. Vanuatu, Solomon Islands, Kiribati), as well as periodic joint monitoring and supportive supervision.

The Solomon Islands newborn care roadmap indicates that neonatal and infant mortality have reduced from 14 and 30 in 2008 to 13 and 22 in 2013 respectively, based upon UNICEF and WHO data.

Output 6: By 2017, 62 hospitals in 14 PICTs are declared 'Mother Baby Friendly'

UNICEF is targeting 21 health facilities under MFAT for support with certification and re-certification. These include FSM (3); Kiribati (2); RMI (2); Nauru (1); Solomon Islands (6); Vanuatu (5).[11] The mother-baby friendly hospital initiative had a baseline of 29 health facilities, accredited, some of which are

[9] Centre for International Child Health, 2016, Newborn care situation analysis and roadmap: Solomon Islands.

[10] UNICEF, MHMS Solomon Islands, Centre for International Child Health Solomon Islands Newborn Health Narrative Summary, October 2016.

[11] Based on available data, since 2002/2005 around 29 hospitals in the PIC are BFHI accredited; several had initiated the process but did not complete the process. In 2015-2016 work already initiated to strengthen capacity for BFHI in Solomon Islands, FSM, Vanuatu and RMI; Fiji Ministry of Health is conducting the reassessment now – discussing with the MoH on the findings for further support or certification.

included in this target: Fiji (21); FSM (1); Kiribati (1); RMI (0); Nauru (0); Solomon Islands (4); Vanuatu (2).

As per the progress report, internal reviews were undertaken in FSM, RMI, Kiribati and Vanuatu to identify capacity gaps; capacity building was initiated in FSM (2016) and planned for Vanuatu and RMI (early 2017).[12] Solomon Islands has also recently undertaken an assessment of previously certified facilities (four) while three additional hospitals have been oriented (the MHMS would like to have all 11 hospitals eventually certified). Kiribati has two hospitals previously certified under the mother-baby-friendly hospital initiative (MBFHI), in South Tarawa and on Christmas Island, but requiring recertification.

Box 5: Mother-baby friendly steps

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk unless medically indicated.
7. Practise rooming in - allow mothers and infants to remain together - 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

As this is considered an intensive process, there is expressed interest in focusing more on the steps (Box 5) and less on certification by UNICEF, however, at least in the Solomon Islands, there a strong interest in certification (seen as motivational for the facilities). In general, UNICEF has noted the need for greater institutional support for this initiative from respective MHMS. That said, Kiribati has adapted and translated the MBFHI for national policy and all tier one countries have included MBFHI in their corporate plans.

Result 6: By 2017, 120,000 children under five (80%) in seven PICs (Solomon Islands, Vanuatu, Samoa, Kiribati, Palau, FSM and RMI) receive quality clinical service for pneumonia (proper antibiotic) and diarrhoea (new ORS and zinc tablets)

Achievements against targets have not been tracked by UNICEF in its progress reports nor was data available at country level in Kiribati and Solomon Islands.[13] However, several activities have been conducted over the course of the MFAT grant. This includes technical support for commodities (e.g. antibiotics, ORS and zinc tablets), planning, costing and implementing IMCI services and training of health workers on IMCI in tier one countries. The cost for IMCI training is shared with government/DFAT funds in the Solomon Islands. UNICEF has also supported the development of Paediatric Standard Treatment and WHO Pocketbook of Hospital Care for Sick Children. This third edition will be launched in March 2017 (the last edition had not been updated since 2007) and 2,500 copies distributed to health workers across the Solomon Islands. It includes treatment guidelines, drug doses and immunization information pertaining to the most common conditions found in the Solomon Islands.

To what extent is the Programme thrust (approach) still valid and the Programme considered to be relevant and useful by partners?

The project was designed for MFAT funding to contribute 41% to UNICEF's MNCH programme; as such, it is embedded within UNICEF's country programme results, programme workplans and

[12] UNICEF Annual Progress Report, April 2015 – March 2016, Submitted to the New Zealand Ministry of Foreign Affairs and Trade (third cumulative progress report).

[13] The Solomon Islands conducted a Demographic and Health Survey in 2015 However this report is currently not available (due in April 2017).

programme reporting. This approach remains valid, relevant and useful to UNICEF and its partners. In tier one countries, MFAT is complementary to other funding sources and is embedded in the national health sector workplans. In the Solomon Islands, it includes support for two non-governmental partners, World Vision International (WVI) and the CICH, working on community-based MNCH and essential new-born clinical care respectively.

Within this broader programme approach, MFAT support is viewed as critical as it is flexible, allowing UNICEF to negotiate bottlenecks and address critical gaps. Gaps mainly take the form of essential equipment and supplies. This is highly valued by national government counterparts. Work with non-governmental partners, WVI and CICH, is strategic, to inform national approaches to community MNCH and scale-up of EENC. The latter is being done in close collaboration with the National Referral Hospital, a centre of excellence within the Solomon Islands context.

The MNCH programme is described by UNICEF as able to adapt in response to strategic and operational needs, particularly in tier one countries where interventions are focused. Programmatic "flex" does appear ad hoc, without an accompanying narrative of the underlying political economy and health systems context. These have also been in flux, changing over the course of the programme. This limits review of the "usefulness" of the programme's thrust over time.

Having some flexibility is important – even critical - to enable UNICEF to be adaptive to a changing environment: changing in both donor landscape and emergency context. The flexibility allows UNICEF to leverage MFAT funds for greater, more synergised results. The critical nature of flexibility comes when it is underpinned with a clear results framework and its application is based on informed decision making.

Are there any critical emerging issues that were not within the scope of the Programme?

The Pacific region is prone to frequent natural disasters and disease outbreaks. These events were not reflected in the programme scope. This has affected the achievement of targets and contributes to the fragility of achievements. During the programme implementation period, UNICEF has provided emergency response for a measles outbreak in the Solomon Islands (2014); rotavirus outbreak in Kiribati (2016); Cyclone Pam in Vanuatu (2015) and Cyclone Winston in Fiji (2016). While emergency response is not funded under MFAT, its flexible approach does allow the programme latitude to respond (within its limited resource envelope). Increasingly, UNICEF has recognised that risk reduction and resilience need to be embedded within its programme approach in the PICTs. [14]

> *"Climate-related hazards represent a critical element in the Pacific, with implications on health services delivery."*

Changes in development status, reflective of gross domestic product (GDP), have not resulted in greater fiscal space with the health sector. They have resulted in the premature "graduation" of countries from global initiatives such as GAVI, with limited attention towards transition to domestic financing. This has implications for the scope of UNICEF's EPI support as it tries to address gaps in resources in affected countries.

This is the case in **Kiribati** which was declared a LMIC in 2015 and is not eligible for GAVI funding from 2017. The economy is fragile, highly reliant on phosphate reserves and foreign fishing licenses, both of which do not hold long-term growth potential (meaning that LMIC status is fragile). This, combined with effects of climate change, population pressure and environmental degradation, leave women and children and the health systems they rely upon highly vulnerable. **Solomon Islands** has greater fiscal

[14] UNICEF Strategy Note for the 2018-2022 Pacific Multi-Country Programme of Cooperation, draft 2017, pg. 23.

space but is spending less on health. It will also transition from GAVI support in 2022 and can be expected to have similar challenges without proactive support and advocacy.[15]

Changing epidemiological patterns and social determinants of health within PICTs. These include an increase in non-communicable diseases (NCDs) related to lifestyle changes and the 'double burden' of poor nutrition (overweight and obesity, coupled with micro-nutrient deficiencies and malnutrition, mainly stunting). These conditions are prevalent in communities, and sometimes within the same household. Other factors include the influence of marketing of breastmilk substitutes (BMS), present in middle-income PICTs but also tier one countries. Women are also more separated from their young children, through formal employment[16] as well as informal work, outside of the home; both present new challenges to optimal breastfeeding and complementary feeding, particularly in growing urban areas.

What are the major factors that influenced the achievement or non-achievement of the Programme outputs?

The combination of UNICEF international technical and national contextual experts (in tier one countries) has contributed to the achievement of programme results. However, the team is lean, in the regional office in Fiji as well as in Kiribati, Solomon Islands and Vanuatu where UNICEF maintains field offices. While UNICEF international staff provide expertise not otherwise available in-country, there is a lack of continuity in this support, largely due to challenges attracting and retaining staff. In 2016, for example, UNICEF was without a MCH specialist since August 2016 (approximately 6 months); and there was an acting Chief of Health and Nutrition for most of the year. This results in disruptions, and at times, can divert focus away from other aspects of MNCH and HSS efforts. Staffing complements by tier one country are lean and include a mix of international and national staff:

- Solomon Islands – Immunisation Officer (international, 2 years); national MNCH officer (10 years).
- Kiribati –national Nutrition officer (in place five years);
- Vanuatu –RMNCAH Coordinator (international staff); EPI Officer (international staff);

Capacity gaps within UNICEF are filled with short term consultants.

Achievements have been driven by UNICEF in contexts where there is limited health system responsiveness (both proactive and reactive). This is a function of the system itself but is also reflective of a lack of individual initiative, and cross departmental coordination within health systems. Capacity gaps are more prominent at sub-national levels particularly the outer islands where there is limited supervision and mentoring support.

Examples of this from Solomon Islands are the stock outs and expired drugs evident in more remote health facilities, while stocks exist in the central warehouse and in health facilities closer to the capital. Often initiative is taken by the frontline health worker with limited response by the Provincial Health Department (PHD). A case in point was the need for a replacement gas cylinder for the vaccine refrigerator. The temperature monitoring chart showed that temperature had been diligently monitored and as it reached the higher threshold, the vaccines were safely removed to the provincial health department. A replacement cylinder had not been provided and vaccination was not taking place.[17] UNICEF, upon learning this, began to make phone calls to the PHD to spur action. Similar issues were observed in Kiribati.

[15] A GAVI consultant was visiting the Solomon Islands at the time of the review to develop plans for accelerated transition/graduation.
[16] Maternity leave in most PICTs is one month.
[17] As noted in: Trip Report, Wendy Erasmus, Solomon Islands December 6-9, 2016: Visit to Marara Area Health Centre December 8th

Are there any unexpected results of the Programme either positive or negative that had not been planned for?

No unexpected results were noted from the programme review.

To what extent have programme activities been embedded in health systems? What factors are influencing this?

The Vaccine Independence Initiative (VII), embedded in national health systems, focuses on strengthening several health system functions as pertain to EPI. Health system building blocks[18] include information (vaccine forecasting and stock and consumption reporting); financing of vaccines (through UNICEF's credit facility); medical technologies (the availability of quality vaccines); and service delivery at primary care levels (through strengthened cold chains and health worker capacity). VII includes forecasting and reporting of vaccine stock and consumption, financing the procurement of vaccines through UNICEF's credit facility, access to quality affordable vaccines, and distribution to PICTs. Recently, VII enabled procurement of cold chain equipment. Country ownership is reinforced as the 14 PICTs pay for their own EPI vaccines, while the Solomon Islands is planning to use the credit line to also buy equipment. Pooled procurement through UNICEF allows for economies of scale, ensures the availability of WHO certified vaccines and reduces the likelihood of stock outs. PICTs pay at the end of each year, including storage and service charges. MFAT supports the credit facility as well as UNICEF technical assistance with forecasting and procurement. This has allowed country traditional vaccine supply to remain "stable and affordable".

Field note: In 2016, UNICEF Fiji sent 52 separate shipments to 13 countries. Separate shipments were required. The initial set up of the cold room storage facility in Fiji, supported by MFAT, allows UNICEF to preposition vaccines for emergencies and to prevent stock outs.

VII has been in place for more than twenty years and remains important given that, individually, PICTs cannot compete on the open market for vaccines.[19] While the VII currently has a life span to 2020, it is unclear if a longer-term strategy to transition this support is envisioned by UNICEF's Executive Board.[20] It is the opinion of the reviewer that UNICEF Pacific should advocate for its continuation. VII, which is almost entirely financed by PICTs, is an important bedrock upon which strengthening of immunisation services have been made, with support from MFAT. In short, the gains made in immunisation coverage would not have been possible without VII, while this foundation has enabled immunisation financing and vaccine and cold chain supply chain to be embedded within the health system.

Weaknesses in health system building blocks are not considered holistically by UNICEF. This is due, in part, to limited resources as well as the orientation of the programme which has a very utility-driven focus on specific interventions and targets. A more system-wide approach to programme intervention, as promoted by WHO, would reframe "success" in terms of programme contribution to overall system progress towards universal health coverage.[21] This orientation is missing as HSS is siloed within interventions.

UNICEF supply chain support has focused on the cold chain, which tier one countries are extremely reliant upon. However, the field visit to Kiribati showed that there were significant weaknesses within the supply chain overall, limiting the availability of essential medicines and commodities in health facilities, even within South Tarawa. This effects overall health system performance as well as the performance of the MNCH programme, particularly results 3,4,5 and 7. Unlike Solomon Islands, which has DFAT support for addressing supply chain functionality, Kiribati has no external support.

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[18] World Health Organisation, 2007. Everybody's Business: strengthening health systems to improve health outcomes (WHO's Framework for Action), WHO, Geneva.

[19] The VII has been providing pooled procurement and bridge-financing support to PICTs since 1995.

[20] As per the third annual progress report, the UNICEF Executive Board (in February 2015) voted to expand the VII to other important life-saving commodities (including essential medicines, nutrition supplies, and bed-nets) and to extend the initiative until 2020.

[21] Sparkes, S., Duran, A. and Kutzin, J.A. System-wide Approach to Analysing Efficiency Across Health Programs. Health Financing Diagnostics and Guidance. World Health Organisation, 2016.

UNICEF maintains an 'on plan, on budget' approach in tier one countries but is only partially 'on system' with MFAT funding given poor absorptive capacity and the need to circumvent system bottlenecks. In the Solomon Islands, most donor funding (dominated by DFAT) is channelled on budget, on plan, on system. While laudable, this has resulted in low utilisation, estimated 26% in 2016, due to poor absorptive capacity of the health system. There is clear rationale for keeping some programmatic functions 'off system', assessing what functions can be consolidated while concurrently ensuring accountability for results.[22] For those that can be consolidated, this should be done progressively with clear milestones.

In Solomon Islands for example, funding is channelled to the national government for training and EPI micro-planning; this results in delays in implementation of activities. In 2016, funding for one province had to be returned as micro-planning was not completed. It was noted by national coordinators that there was very little room to adjust the plan once it was finalised – highlighting one of the constraints faced by development partners committed to working 'on system'. For example, while MBFHI assessments were conducted in early 2017, as implementation of findings was not included in the workplan, it was unclear if or when these could be implemented in 2017.

MHMS requirements for being 'on system' in both Vanuatu and Kiribati are more flexible with Kiribati being the most flexible. MHMS Vanuatu workplans allow unfunded activities to be included with confirmation of funds coming through a review process. Kiribati also allows adjustments to their workplan throughout the year.

UNICEF is actively engaged in advocating for domestic financing and addressing systems bottlenecks. UNICEF, with support of its social policy section (currently not funded under MFAT), has capacity to implement public expenditure tracking surveys (PETS) to identify bottlenecks in public expenditure. The PETS methodology, developed by the World Bank, seeks to trace the flows and uses of resources through the various layers of government to service facilities to identify differences between the official and actual allocations and to determine the extent to which resources reach service providers and users.[23] While these have not been conducted in PICTs to date, UNICEF is planning to conduct these.

To what extent have gender, disability and environmental concerns been taken into consideration during the programme? How can these be better addressed in future?

There was no specific focus on disability or gender noted from the review. For example, there has been no deliberate attention paid to male involvement in MNCH. Immunization data is not sex-disaggregated; however, there is no reason to believe that children are not immunized based on their sex (high coverage rates also support this). The introduction of the HPV vaccination is targeted at girls 9-12 years of age. As the vaccine is linked to sexually transmitted diseases, it is important that sexual activity is not inferred due to this. UNICEF has had a consultant working in both Solomon Islands and Kiribati on C4D, which addresses this and other issues. Better attention to disability and gender should be considered for future programmes, guided by UNICEF Pacific's strategic plan (2018-2022).

[22] Sparkes, S., Duran, A. and Kutzin, J.A. System-wide Approach to Analysing Efficiency Across Health Programs. Health Financing Diagnostics and Guidance. World Health Organisation, 2016.

[23] Gauthier, B. and Z. Ahmed, 2012. Public Expenditure Tracking Surveys (PETS) and Quantitative Service Delivery Survey (QSDS) Guidebook. World Bank, Washington, DC.

UNICEF is working with the MHMS in tier one countries to decommission old cold chain equipment and introduce solar technology. Currently, cold chains are a mix of electricity, gas, kerosene and solar. MFAT funding has supported solar conversion in Solomon Islands and Kiribati, however, this is far from complete while emergency funding in the aftermath of Cyclone Pam, has allowed for a more accelerated solar upgrade programme in Vanuatu. This is employing a solar technology option that provides a power bank for lighting health facilities at night, identified through UNICEF's environmental unit.

In 2016, UNICEF provided technical assistance to selected PICTs on 'Appropriate Technology Assessment'. This has facilitated dialogue on environmental and sustainable energy needs and their inclusion and impact on resilience in national policy, programme and technical assistance plans.

Source: UNICEF third annual progress report

UNICEF provides technical and material support to MHMS cold chain technicians for maintenance and repairs of cold chain equipment (to reduce the frequency of replacement). This support is critical as it is very difficult to source some tools and spare parts in most of the PICTs nor is it easy to dispose of large equipment in an environmentally responsible manner in these contexts. UNICEF has pre-selected four third party service providers located in Fiji, three of which have operations in Kiribati, Vanuatu and Solomon Islands. These suppliers provide skills transfer to national technicians (for example, Solomon Islands Cold Chain Coordinator attended a training in Fiji in 2016, supported by UNICEF). In Kiribati, more support is needed for cold chain operations and maintenance due to operational bottlenecks and information deficits, e.g. a lack of up-to-date asset registers for health facilities (for any equipment). In the facilities visited, there were cases of new freezers side-by-side with freezers in need of repair.

While not under current UNICEF support, medical supply chain wastage in Kiribati is an environmental concern. In the four health facilities visited in North and South Tarawa, there were a number of expired products on the shelves (with more due to expire in Feb and March 2017). Health workers complained of being sent products with short expiry dates. They also indicated that it is the central pharmacy which determine the quantities and mix of medicines supplied. When probed on disposal of medicines, health workers did not appear to follow any protocol with syrups, pills, capsules, etc. removed from their containers and thrown away (reportedly dissolved in water) while the containers are said to be recycled.

Vaccine wastage assessments have been technically supported in selected PICTs by UNICEF in collaboration with the Centre for Disease Control and WHO in 2015 (Fiji and the Solomon Islands).

Source: UNICEF third annual progress report

What investments have been made by other actors in the MNCH space during the course of the Programme and to what extent has there been complementarity, coordination or duplication?

MFAT support, focused on routine vaccinations[24] has provided the "backbone" for introducing new vaccines, largely funded with other resources. This is complementary to MFAT funding and well-coordinated by UNICEF Pacific. The new vaccines initiative has been supported in Vanuatu and Kiribati, by the Japanese and Australian National Committees and by Australian Department of Foreign Affairs and Trade (DFAT) in the Solomon Islands. This initiative has piloted the introduction of PCV (infants per Penta schedule), rotavirus (infants up to 2 years of age), and HPV (9-12 years of age, girls). With these additional vaccines, the cost per annum for PICTs would increase to USD $7-8 million with concomitant increases in storage and distribution requirements. VII pool vaccine requirements in the Pacific to maximise economies of scale and leverage procurement power. UNICEF is in the process of finalising a grant with the Asia Development Bank and Australian Rotary for USD $ 21 million for four countries for five years for new vaccines.

[24] As per the background section in the TOR, the Australian government also provided financial support for broad regional immunization activities until June 2015.

The UN RMNCAH Joint Programme, focused on high morbidity and mortality RMNCAH conditions, has clear synergies with interventions supported under MFAT. Funded by DFAT, UNICEF leads this initiative in Vanuatu while WHO and UNFPA are the leads in Solomon Islands and Kiribati respectively. Coordination is facilitated, and duplication reduced, through the inclusion of development partner contributions to MHMS annual workplans in Kiribati, Vanuatu, and Solomon Islands (Box 6). In the workplans, each MHMS activity is budgeted. Through an MHMS led planning process with all development partners, each activity is funded (or not, either partially or wholly), indicating the funding amount and funding source – in the case of UNICEF, it will state UNICEF as the donor. MFAT funding and other funding sources is included within these workplans as part of UNICEF's total contribution to any given activity. Bilateral funding and MHMS recurrent funding is also indicated in the plan. However, a review of the Kiribati workplan suggests that this would benefit from greater detail/specificity, action orientation, and clear timelines in order to improve mutual accountability amongst development partner and government actors.

Field note: NCDs – technically supported by WHO - are allocated 50% of the health programme budget in Kiribati while stunting has no government funding.

For the other 11 countries, UNICEF's commitment to government is articulated through a standard exchange of letters globally used within UNICEF with an attached workplan signed by both government and UNICEF.

Box 6: UN Joint Programme and national RMNCAH workplans

Kiribati: There is a national RMNCAH workplan developed (for 2017), which the MFAT programme contributes towards. MFAT funding is integrated within this workplan but earmarked as such (e.g. it is distinguishable from DFAT Joint Programme funds). Other partners are also starting to be visible within this workplan, for example, the Kiribati Family Planning Association and Child Fund New Zealand. Integrated visits have been initiated to the outer islands as of 2016 in order to improve efficiency and the range of RMNCAH services and quality oversight provided. There is a national RMNCAH Steering Committee which meets on a monthly basis in order to harmonize activities.

Solomon Islands: While the same principles apply in Solomon Islands, due to a greater number of partners, alignment is more challenging. However, MFAT funds are delineated within the jointly-owned workplan (under the heading of UNICEF). It is unclear how devolved the workplan is to the provinces.

While RMNCAH provides a good framework for coordination and complementarity, in practice there is room for improvement. In addition to improved planning (previously noted), more attention to 'joining up' technical support and harmonization of communication materials is needed. This also plays out in terms of relative attention paid by governments to specific RMNCAH conditions (e.g. NCDs) as compared to stunting, despite evidence of the linkages between stunting and obesity.[25]) or services, such as family planning, which are not fully embraced in tier one countries. This would improve the continuum of care, as intended, from where one agency support ends and another takes over. This was noted with family planning, in the domain of UNFPA, but critical to UNICEF's interventions to improve health and nutrition of mothers, infants and young children.

In the Solomon Islands, MFAT support is considered highly complementary to support provided through the Health Sector Support Programme (HSSP). Complementarity is reinforced through close planning and budgeting with the MHMS as well as DFAT advisors. This is evidenced not only in Solomon Islands but in Kiribati and Vanuatu where annual joint planning and budget sessions are led by MHMS and include all development partners. The process begins with defining priorities, detailing activities within those priorities and declaring existing and planned resources by all actors. The process is documented in a workplan with progress reported on at MHMS led development partner coordination

[25] Hoffman, D., Sawaya, A, Verreschi, L, Tucker, K and S. Roberts, 200. Why are nutritionally stunted children at increased risk of obesity? Studies of metabolic rate and fat oxidation in shantytown children from São Paulo, Brazil. American Journal of Clinical Nutrition; 72:702–7.

group meetings. Workplans and budgets are updated at least once per year. This process has enabled coordination, fostered complementarity, and reduced duplication.

MFAT funding is complimentary to DFAT HSSP, which is about to commence its third iteration. DFAT resources are allocated to a core MHMS budget (approximately AUD $11 million); an additional AUD $1.75 million is performance-based; while AUD $8 million is provided through direct technical assistance. There is a process of decentralised funding to the provinces but this is still in the initial stages and not functioning optimally.[26]

5. Lessons Learnt and Recommendations

The review was requested to respond to the following questions:

- *What are the lessons learned and recommendations for future consideration?*
- *What could be the recommended focus areas for the future programme to make the biggest impact on maternal, newborn and child health in alignment with national priorities of the Governments?*

5.1 Lessons

Lessons identified at MFAT proposal development in 2012, remain valid in 2017. While some progress has been made, continued attention to these areas is suggested.

- A **supportive policy environment** is crucial for improving MNCH, with the commitment from the highest level and inclusion of these areas in health sector strategic plans. Service provision should be ensured along the entire maternal-child-adolescent continuum and across all levels of the health system with continued efforts to develop action plans.
- To scale up implementation of evidence-based interventions in MNCH towards universal coverage, the **capacities of the health workforce** need to be maintained and further strengthened. This entails both clinical and management skills as well as communication and counseling skills (for preventive and promotive actions).
- Tracking progress requires **accurate, reliable and timely routine monitoring data**, generated through government health information and surveillance systems. Maternal and child death audits should form part of this and be used to address weaknesses found within the health system.
- To ensure **continuum of care** across levels of care and along the life course, close coordination across relevant programmes and key partners is necessary. This should extend to communities.

Field note: As reported by MHMS managers, Kiribati has 26 registers (including seven for under-fives). While Solomon Islands has five registers (as reported by health workers met as part of the review) it has more than one hundred HMIS indicators (which it is trying to rationalize). Observations from health facilities in Kiribati indicate that there was some confusion by health workers in data reporting. Valiant efforts were being made however to complete all registers!

Lessons emerging from this programme period, not previously noted at proposal development, include the following:

UNICEF has **multiple strategies for MNCH** (Box 7), with some overlap and competition for attention, within UNICEF as well as with counterparts (some funded through MFAT and others not). UNICEF could streamline its strategic approach by integrating and being more selective with strategies it is supporting.

[26] Information from: Trip Report, Wendy Erasmus, Solomon Islands December 6-9, 2016, Development Partners Coordination Group Meeting (DPCG) December 7th, 2016.

Box 7: MNCH strategies documented or referred to during the review

- At health facility level - MBFHI; IMCI; EENC; emergency obstetric and new-born care (EmONC); integrated management of acute malnutrition (IMAM); nutrition in emergencies
- At community level - maternal child health and nutrition '7-11' strategy (WVI); infant and young child feeding; community-based maternal and neonatal care (CBNMC); IMCI community module; maternal, infant, and child nutrition (MIYCN, proposed as the 'new' strategy)
- Vaccine support also has multiple strategies but is more focused on an integrated package under VII

Community involvement in MNCH, while critical, has had limited impact and reach. In Kiribati, the UNICEF-supported CBNMC activity has seen a 92% attrition rate of trained youth health volunteers. No attempt has been made to evaluate impact. In the Solomon Islands, UNICEF support to WVI's programme also has issues with attrition (personal communication, WVI meeting). This programme has limited reach (and is costly), targeting only 10% of the population in Temotu province, in seven communities (estimated at 2,136 individuals). Efforts have been made to establish impact in other sites where WVI is implementing the same approach with other funding, with positive findings.[27] Learnings from these efforts should be captured and disseminated.

Outreach, supportive supervision and on-the-job training are limited in tier one countries visited. In Kiribati, integrated outreaches are done to the outer islands on an annual basis with UNICEF and UN Joint Programme support. In Solomon Islands, EPI outreach activities are conducted with UNICEF support but are not integrated with other MNCH activities (although the national EPI Coordinator did report that she used her EPI field staff to look at other health areas). In all the health facilities visited in both countries, health workers did not report any supportive supervision visits in the last year (and some indicated upwards of two years). On-the-job training is done by UNICEF when it visits health facilities (this was observed during the field visit to Kiribati) but does not appear to be practiced by the MHMS in these contexts.

Field note: Outreach teams in Kiribati do feedback findings from their integrated visits to Island Councils and Mayors. They receive good cooperation from the village councils. The church, which has a strong influence and presence in Kiribati, is not adequately engaged. These structures could be considered as part of a community engagement strategy. In both Solomon Islands and Kiribati the importance of male involvement in MNCH was raised. Some local strategies were being employed to cultivate this.

Limited 'domestication' of strategies and guidelines. UNICEF has relied upon global strategies and training packages, which are then used as a basis for national trainings or other intervention. This may be one of the reasons that multiple strategies are being used in tier one countries as adaptation and domestication has not occurred. This would entail user-friendly guidance and protocols disseminated down to front line workers.

Opportunity for greater peer learning amongst PICTs. While not highlighted as a lesson as such, field visits indicate that peer learning between tier one countries (as well as with other PICTs) may be beneficial. Reporting and analysis of data would be a good entry point given the differences in data quality, completeness, tools and capacity observed as part of the field visits.

5.2 Recommendations

Programmatic and operational flexibility needs to be underpinned by sound results logic, with HSS as an over-arching strategy. The results logic should address intervention points across the socio-ecological model (from the individual through to the institutional). This does not mean that UNICEF needs to spread MFAT resources thinly, but rather, resource targeting should have a clear "line of sight" from the mother and child – to community – to health facilities – to institutions. This

[27] World Vision International, 2016. Maternal Child Health and Nutrition (MCHN) Project Evaluation, Health Development Partners Meeting June 9th, 2016, Honiara, Solomon Islands.

requires greater accountability of and between partners towards this end. At present, the absence of results logic, capturing causal linkages, has made it very difficult for UNICEF to track progress.

Decisions on intervention pathways should be documented to improve knowledge – and contract - management as well as understanding of contextual changes within and across PICTs. UNICEF internal processes, including protocols for adjustments to its programmatic scope need to be clearly documented and communicated, internally as well as with donors such as MFAT. This is particularly important given staff turnover and the need for a repository for "institutional memory". Similarly, decisions on what functions should be progressively "on system" should be documented, outlining trade-offs and milestones.

Future programming should be conceptualised using UNICEF's new strategic framework for the period 2018-2022.[28] This is based upon a socio-ecological model (Box 8) and would reduce "siloed results" as currently framed. HSS is framed as the underlying approach and not as a separate strategic area as currently presented in the MFAT results framework.

Box 8: UNICEF new strategic framework

UNICEF strategic outcome - By 2022, children in the Pacific, particularly the most vulnerable, increasingly benefit from quality and resilient health and nutrition services and care practices.

- Output 1: National capacities enhanced to strengthen quality health and nutrition policy and legislation, particularly in target countries.
- Output 2: Health system capacities strengthened to deliver quality health and nutrition services that are adapted to the impacts of climate change, particularly in target countries.
- Output 3: Caregivers have improved knowledge and skills to adopt recommended health and nutrition care practices, particularly in target countries.

Deliver more targeted technical assistance, with greater attention to sub-national levels to yield greater impact of MNCH resources. This should focus on addressing bottlenecks, improving quality and continuity across the RMNCAH continuum of care, and fostering synergies with other partners given UNICEF's focus on 1,000 days and MNCH. UNICEF could "lead by example" by working with the central MHMS to improve the frequency and quality of integrated outreaches, supportive supervision and on-the-job training, focused on addressing gaps in quality and service delivery at peripheral health facilities. This would also serve to reduce reliance on the trickle down of "blanket training" as is currently practiced. Intervention should be underpinned by bottleneck analysis as well as PETS, with support from UNICEF's social policy section.

Maintain support for routine vaccinations, through the VII, as coverage remains fragile and PICT capacity to procure vaccines doubtful. VII should continue to be leveraged for the new vaccine initiative, supported with other resources. While this initiative will continue in the midterm, UNICEF Pacific should advocate for its continuation after 2020, combined with a PICT transition plan for sustainable financing of EPI. UNICEF could also avail the credit line facility to PICTs for the procurement of essential equipment such as height boards and scales as a means of weaning off UNICEF financing.

MNCH would benefit from a more strategic and focused approach, doing 'less, well'. Greater emphasis should be placed on the institutionalization of MNCH strategies where these exist, and consensus on their development where these are missing. For nutrition, this should be framed around the "1,000 days" and stunting, given its prevalence (the MBFHI could be included as one strategy under this framework). Emergency intervention, in response to natural disasters, should use this framework as a starting point, and not maintain a separate entry point as this reinforces the notion of malnutrition as an "event" and not a condition. UNICEF should also consider technical support for the development

[28] UNICEF Strategy Note for the 2018-2022 Pacific Multi-Country Programme of Cooperation, draft 2017.

of national community health strategies, surprisingly absent in tier one countries with the full RMNCAH continuum considered as part of this.[29]

The remainder of the MFAT grant period should be used to consolidate activities and lay a foundation for UNICEF's new country programme. Box 9 outlines UNICEF programmatic priorities. These will be underpinned by attention to improved internal processes, such as knowledge management and documentation of programmatic decisions.

Box 9: UNICEF priorities for the remainder of the current MFAT grant

UNICEF plans to consolidate MNCH activities, setting the stage for the new country programme. Specifically, UNICEF will focus on establishing the foundation for community based health care, supportive supervision and consolidating gains in immunisation, newborn care, and nutrition. Within immunisation, UNICEF will support PICTs to target hard to reach children; in nutrition, emphasis will be placed on providing micronutrients and other nutrition supplies and equipment, training on MIYCN, BFHI and IMAM. These activities will provide a good foundation for the new country programme, focused on 1,000 days, newborn care, and sub-national HSS.

[29] In Solomon Islands a Heathy Islands, Health Communities concept has been developed which includes health and nutrition amongst other interventions. The reviewer was unable to get a copy of this.

Annex 1: Review framework

Data methods and sources of information per review question are presented in Table 1. The blue squares indicate strong reliance on the method whilst the "x" signifies less reliance on the method.

Review questions	Internal data sources	External Data Sources	Field Observations	External KIIs	Internal KIIs
To what extent is the Programme thrust (approach) still valid and the Programme is considered to be relevant and useful by partners? In what ways should it be changed/adapted?	x	x	x	x	x
Are there any critical emerging issues that were not within the scope of the Programme?	x	x	x	x	x
Does the results framework provide an appropriate framework to support the achievement of the identified results?	x				x
What output targets were achieved as a result of the programme? To what extent will/have these achievements contributed to the programme outcomes?	x		x	x	x
What are the major factors that influenced the achievement or non-achievement of the Programme outputs?	x	x	x	x	x
To what extent have programme outputs been embedded in health systems? What factors are influencing this?	x	x	x	x	x
Are there any unexpected results of the Programme either positive or negative that had not been planned for?	x	x	x	x	x
To what extent have gender, disability and environmental concerns been taken into consideration during the programme? How can these be better addressed in future?	x	x	x	x	x
What investments have been made by other actors in the MNCH space during the course of the Programme and to what extent has there been complementarity, coordination or duplication?	x	x	x	x	x
What are the lessons learned and recommendations for future consideration? What could be the recommended focus areas for the future programme to make the biggest impact on maternal, newborn and child health in alignment with national priorities of the Governments?	x	x	x	x	x

Annex 2: List of documents reviewed

Kiribati

Republic of Kiribati, Ministry of Health and Medical Services, monitoring tool [updated]

Republic of Kiribati, Ministry of Health and Medical Services, Cold Chain Guideline

Republic of Kiribati, Ministry of Health and Medical Services and UNICEF, Jan 2017. EPI Strategic Communications Plan

Republic of Kiribati, Ministry of Health and Medical Services and WHO, 2012. Health Service Delivery Profile

Republic of Kiribati, Ministry of Health and Medical Services, December 2015. National Multi-Year Plan for Immunization in 2013-2018.

Republic of Kiribati, Ministry of Health and Medical Services, 2015. Ministry Strategic Plan 2016-2019.

Kiribati MHMS, 2017. Briefing for the Review of the New Zealand Ministry of Foreign Affairs and Trade (MFAT) MNCH-supported programme (power point presentation).

Kiribati MHMS, Guideline for updating health facilities micro-plans for reaching every community

Cantin, I., April 4, 2016, Summary of the Consultancy's activities related to the Polio Switch and its Supply Chain, Kiribati

Robert Condon, 14 February 2014. Options for Australian and New Zealand development assistance in health, Kiribati Concept Note. Health Resource Facility Mott MacDonald (Mott MacDonald Australia Pty Ltd) in association with IDSS.

Kiribati MHMS, 2017 annual RMNCAH corporate business plan, Tarawa, Kiribati

Trip Report, Wendy Erasmus, Kiribati, January 9th-12th, 2017

Solomon Islands

World Vision International, 2016. Maternal Child Health and Nutrition (MCHN) Project Evaluation, Health Development Partners Meeting June 9th, 2016, Honiara, Solomon Islands.

Centre for International Child Health, 2016, Newborn care situation analysis and roadmap: Solomon Islands.

Centre for International Child Health, 2016, Solomon Islands Newborn Health Narrative Summary, submitted to the MHMS and UNICEF Solomon Islands.

Cain, J, 2016. Health Equity Analysis: Solomon Islands Consultation on Initial Findings from the 2012/2013 Household Income and Expenditure Survey (HIES), Health Nutrition and Population, East Asia and the Pacific, World Bank

Solomon Islands MHMS, 2017 annual RMNCAH corporate business plan, Honiara, Solomon Islands

Vanuatu

Vanuatu Ministry of Health, WHO and UNICEF, 2016. Vanuatu Vaccination Coverage Survey.

Regional

Tyson S. and J. Clements, 2016. Strengthening Development Partner Support to Immunisation Programs in the Pacific Strategic Review, Mott MacDonald.

UNICEF Strategy Note for the 2018-2022 Pacific Multi-Country Programme of Cooperation, draft 2017.

UNICEF Annual Progress Report, April 2015 – March 2016, Submitted to the New Zealand Ministry of Foreign Affairs and Trade (third cumulative progress report).

UNICEF presentation, January 2017. Proposed Revisions for the Programme Outcome Indicators. UNICEF and New Zealand Ministry of Foreign Affairs and Trade High Level Committee Meeting, Suva, Fiji.

UNICEF and MFAT, 2013. Contribution Arrangement between MFAT and UNICEF Concerning Support for UNICEF-Supported Pacific MNCH Programme.

Global

Gauthier, B. and Z. Ahmed, 2012. Public Expenditure Tracking Surveys and Quantitative Service Delivery Survey Guidebook. World Bank, Washington, DC.

Sparkes, S., Duran, A. and Kutzin, J.A. System-wide Approach to Analysing Efficiency Across Health Programs. Health Financing Diagnostics and Guidance. World Health Organisation, 2016.

World Health Organisation, 2007. Everybody's Business: strengthening health systems to improve health outcomes (WHO's Framework for Action), WHO, Geneva.

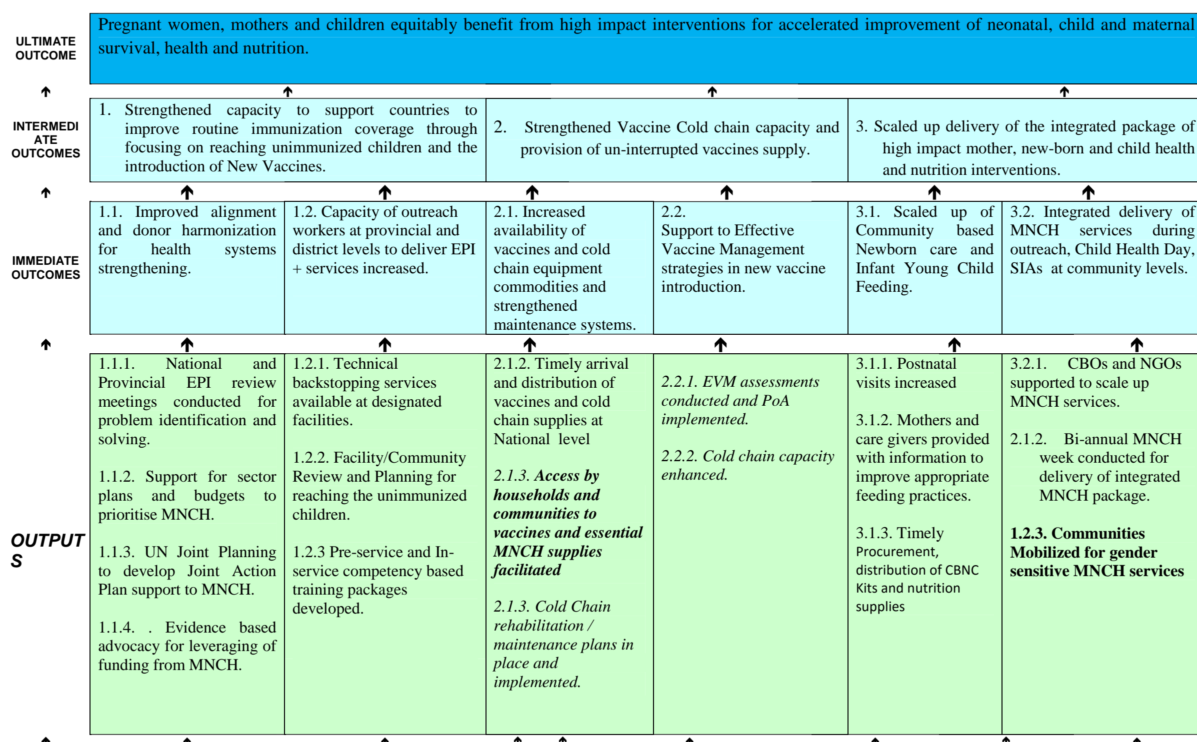
Annex 3: List of People Consulted

Person	Title	Organisation, Location
UNICEF and UN Joint Programme		
Sheldon Yett	Representative	UNICEF Pacific, Suva
Wendy Erasmus	Chief of Child Survival and Development	UNICEF Pacific, Suva
Murat Hakan Ozturk	Procurement Services Specialist	UNICEF Pacific, Suva
Uma Palaniappan	Nutrition Specialist	UNICEF Pacific, Suva
Stanley Ganure Gwavuya	Social Policy Specialist	UNICEF Pacific, Suva
Kang Yun Jong	Chief of Field Office	UNICEF Solomon Islands
Ibrahim Dadari	EPI Programme Officer	UNICEF Solomon Islands
Winston Pitakomoki	Health and Nutrition Programme Officer	UNICEF Solomon Islands
Cromwell Bacareza	Chief of Field Office	UNICEF Kiribati
Mohammed Diaaldeen Salih Abdalla	EPI Consultant	UNICEF Kiribati
Tinai Luta	Health and Nutrition Programme Officer	UNICEF Kiribati
Dr Shayam Pathak	UN Joint Programme Coordinator	UNFPA Kiribati
Dr Ezekiel Nukuro	WHO Country Liaison Officer	WHO Kiribati
MFAT**		
Jonathan Rowe	Development Counsellor	MFAT, Suva
Vamarasi Mausio	Development Programme Coordinator, Regional	MFAT, Suva
Sumi Subramanium	Principal Development Manager Health	MFAT, Wellington, New Zealand
Esther jens	Second Secretary Development	New Zealand High Commission – Honiara
Tauaasa Taafaki	Deputy High Commissioner / First Secretary Development	New Zealand High Commission – Tarawa
Government and partners		
Terengauea Nganga	Central District Public Health Nurse Officer (DPNO)	Kiribati MHMS, Tarawa
Tikua Tekitanga	EPI Assistant (UNICEF consultant)	Kiribati MHMS, Tarawa
Tiroia Teikaka	RMNCAH Coordinator	Kiribati MHMS, Tarawa
Beia Tabweia	EPI Coordinator	Kiribati MHMS, Tarawa
Tiareh Mareko	DPNO, family planning	Kiribati MHMS, Tarawa
Willie Horoto	National Medical Stores Manager	Honiara, Solomon Islands
Scott Wanebem	National Cold Chain Technical Coordinator	Honiara, Solomon Islands

Susie Lake	Planning Advisor (DFAT)	Honiara, Solomon Islands
Jenny Anga	National EPI Coordinator	MHMS, Honiara, Solomon Islands
Salome Diatalau	National Nutrition Coordinator	MHMS, Honiara, Solomon Islands
Dr. Titus Nagi	Paediatric Consultant	National Referral Hospital, Honiara, Solomon Islands
Nethlyn Firibae	EPI/Child Health Programme Officer	Honiara, Solomon Islands
Anne Leo	Nutrition Programme Officer	Honiara, Solomon Islands
Anna Rauco	Pikinini Clinic (in-Charge Nurse)	Honiara, Solomon Islands
Mindy Roduner	WVI Grants Programme Manager	Honiara, Solomon Islands
Everlyn Darcy	WVI Programme Manager	Honiara, Solomon Islands
Margaret Mara	RN In-charge	Taroniara RHC/AHC, Central Province, Solomon Islands
Edward Rahari	Provincial Cold Chain Manager	Tulagi Hospital, Central Province, Solomon Islands
Jenny Narasil	EPI Coordinator	Tulagi Hospital, Central Province, Solomon Islands
Emmy Keipui	Nurse In-charge, Labour Ward	Tulagi Hospital, Central Province, Solomon Islands
Saerin	Nurse In-charge	Visale Clinic, Guadalcanal Province
Alice	Nurse In-charge	Selwyn Aid Post, Guadalcanal Province
	Nurse In-charge	Marara Area Health Centre, Guadalcanal Province

The reviewer would like to note that significant effort was made to meet MFAT officials in country - both in Kiribati and Solomon Islands. Despite additional efforts to contact MFAT officials, they were unable to be reached. At this point, both Kiribati and Solomon Islands MFAT officials indicated that they would rather read the report and provide feedback. Details of this exchange are available upon request.

Annex 4: Original results framework



Level						
ULTIMATE OUTCOME	Pregnant women, mothers and children equitably benefit from high impact interventions for accelerated improvement of neonatal, child and maternal survival, health and nutrition.					
INTERMEDIATE OUTCOMES	1. Strengthened capacity to support countries to improve routine immunization coverage through focusing on reaching unimmunized children and the introduction of New Vaccines.		2. Strengthened Vaccine Cold chain capacity and provision of un-interrupted vaccines supply.		3. Scaled up delivery of the integrated package of high impact mother, new-born and child health and nutrition interventions.	
IMMEDIATE OUTCOMES	1.1. Improved alignment and donor harmonization for health systems strengthening.	1.2. Capacity of outreach workers at provincial and district levels to deliver EPI + services increased.	2.1. Increased availability of vaccines and cold chain equipment commodities and strengthened maintenance systems.	2.2. Support to Effective Vaccine Management strategies in new vaccine introduction.	3.1. Scaled up of Community based Newborn care and Infant Young Child Feeding.	3.2. Integrated delivery of MNCH services during outreach, Child Health Day, SIAs at community levels.
OUTPUTS	1.1.1. National and Provincial EPI review meetings conducted for problem identification and solving. 1.1.2. Support for sector plans and budgets to prioritise MNCH. 1.1.3. UN Joint Planning to develop Joint Action Plan support to MNCH. 1.1.4. . Evidence based advocacy for leveraging of funding from MNCH.	1.2.1. Technical backstopping services available at designated facilities. 1.2.2. Facility/Community Review and Planning for reaching the unimmunized children. 1.2.3 Pre-service and In-service competency based training packages developed.	2.1.2. Timely arrival and distribution of vaccines and cold chain supplies at National level *2.1.3.* ***Access by households and communities to vaccines and essential MNCH supplies facilitated*** *2.1.3. Cold Chain rehabilitation / maintenance plans in place and implemented.*	*2.2.1. EVM assessments conducted and PoA implemented.* *2.2.2. Cold chain capacity enhanced.*	3.1.1. Postnatal visits increased 3.1.2. Mothers and care givers provided with information to improve appropriate feeding practices. 3.1.3. Timely Procurement, distribution of CBNC Kits and nutrition supplies	3.2.1. CBOs and NGOs supported to scale up MNCH services. 2.1.2. Bi-annual MNCH week conducted for delivery of integrated MNCH package. **1.2.3. Communities Mobilized for gender sensitive MNCH services**

Annex 5: Performance coverage

Countries	Forecasted birth cohort for 2015	MCV 1 Coverage	# of Vaccinated Children	Pol 3 Coverage	# of Vaccinated Children	HepB Birth Dose Coverage	# of Vaccinated Children
Cook Islands	250	99%	248	99%	248	99%	248
Fiji	20,900	94%	19,646	99%	20,691	90%	18,810
FSM	2,700	91%	2,457	71%	1,917	69%	1,863
Kiribati	3,340	84%	2,806	76%	2,539	96%	3,207
Nauru	368	98%	361	91%	335	99%	364
Niue	30	99%	30	99%	30	99%	30
Palau	305	95%	290	89%	272	99%	302
RMI	1,640	75%	1,296	85%	1,263	99%	1,246
Samoa	6,000	69%	4,140	61%	3,660	72%	4,320
Solomon Islands	17,700	92%	16,284	99%	17,523	65%	11,505
Tonga	2,900	67%	1,943	84%	2,436	89%	2,581
Tuvalu	300	94%	282	96%	288	98%	294
Vanuatu	8,300	53%	4,399	65%	5,385	80%	6,640
Total:	**64,733**	**84%**	**54,182**	**87%**	**56,587**	**79%**	**49,966**

Vanuatu Coverage Survey Results, 2016

	WHO-Unicef Joint Reporting Form on Immunization Administrative coverage data (%)						**Vanuatu Vaccination Coverage Survey 2016: % coverage 12-23mo* at time of survey (95%CI)^**	
Vaccine	**2011**	**2012**	**2013**	**2014**	**2015**	**Average 2011-15**	**By card or recall***	**By card only**
BCG	93.4	103.3	88.6	97	91	94.7	94.6% (92.5-96.8%)	57.1% (51.7-62.4%)
DTP-Hib-HepB 1	101.7	102.6	86.8	101	89	96.2	94.0% (91.6-96.4%)	57.7% (52.4- 63.0%)
DTP-Hib-HepB 3 (DPT3)	91.7	95.5	75.0	92	81	87.0	81.1% (77.5-84.7%)	52.4% (46.7- 58.0)
tOPV 3 (Polio3)	88.5	95.6	75.0	88	80	85.4	81.3% (77.7-84.9%)	52.1% (46.5- 57.8%)
MR* (MCV1)	91.8	94.2	64.7	91	75	83.3	84.0% (79.9- 88.0%)	41.3% (36.3-46.2%)